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HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS SERVICE

OPERATING HANDBOOK

OF

POLICIES AND PROCEDURES

FOREWORD

(A statement on content and plan for posting and updating of information.

(Include appropriate address to whom inquiries should be forwarded.)

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INTRODUCTION

Chapter I

HISTORY AND PURPOSES OF REGIONAL MEDICAL PROGRAMS

On October 6, 1965, the President signed Public Law 89–239. It authorizes the establishment and maintenance of Regional Medical Programs to assist the Nation's health resources in making available the best possible patient care for heart disease, cancer, stroke and related diseases. This legislation, which will be referred to in these *Guidelines* as The Act, was shaped by the interaction of four antecedents: the historical thrust toward regionalization of health resources; the development of a national biomedical research community of unprecedented size and productivity; the changing needs of society; and finally, the particular legislative process leading to The Act itself.

The concept of regionalization as a means to meet health needs effectively and economically is not new. During the 1930's, Assistant Surgeon General Joseph W. Mountin was one of the earliest pioneers urging this approach for the delivery of health services. The national Committee on the Costs of Medical Care also focused attention in 1932 on the potential benefits of regionalization. In that same year, the Bingham Associates Fund initiated the first comprehensive regional effort to improve patient care in the United States. This program linked the hospitals and programs for continuing education of physicians in the State of Maine with the university centers of Boston. Advocates of regionalization next gained national attention more than a decade later in the report of the Commission on Hospital Care and in the Hospital Survey and Construction (Hill-Burton) Act of 1946. Other proposals and attempts to introduce regionalization of health resources can be chronicled, but a strong national movement toward regionalization had to await the convergence of other factors which occurred in 1964 and 1965.

One of these factors was the creation of a national biomedical research effort unprecedented in history and unequalled anywhere else in the world. The effect of this activity is intensified by the swiftness of its creation: at the beginning of World War II the national expenditure for medical research totaled $45 million; by 1947 it was $87 million; and in 1967 the total was $2.257 billion—a 5,000 percent increase in 27 years. The most significant characteristic of this research effort is the tremendous rate it is producing new knowledge in the medical sciences, an outpouring which only recently began and which shows no signs of decline. As a result, changes in health care have been dramatic. Today, there are cures where none existed before, a number of diseases have all but disappeared with the application of new vaccines, and patient care generally is far more effective than even a decade ago. It has become apparent in the last few years, however, (despite substantial achievements), that new and better means must also be found to convey the ever-increasing volume of research results to the practicing physician and to meet growing complexities in medical and hospital care, including specialization, increasingly intricate and expensive types of diagnosis and treatment, and the distribution of scarce manpower, facilities, and other resources. The degree of urgency attached to the need to cope with these issues is heightened by an increasing public demand that the latest and best health care be made available to everyone. This public demand, in turn, is largely an expression of expectations aroused by awareness of the results and promise of biomedical research.

In a sense, the national commitment to biomedical investigation is one manifestation of the third factor which contributed to the creation of Regional Medical Programs: the changing needs of society—in this case, health needs. The decisions by various private and public institutions to support biomedical research were responses to this societal need perceived and interpreted by these institutions. In addition to the support of research,

the same interpretive process led the Federal Government to develop a broad range of other programs to improve the quality and availability of health care in the Nation. The Hill-Burton Program which began with the passage of the previously-mentioned Hospital Survey and Construction Act of 1946, together with the National Mental Health Act of 1946, was the first in a series of post-World War II legislative actions having major impact on health affairs. When the 89th Congress adjourned in 1966, 25 health-related bills had been enacted into law. Among these were Medicare and Medicaid to pay for hospital and physician services for the Nation's aged and poor; the Comprehensive Health Planning Act to provide funds to each state for non-categorical health planning and to support services rendered through state and other health activities; and Public Law 89–239 authorizing Regional Medical Programs.

The report of the President's Commission on Heart Disease, Cancer, and Stroke, issued in December 1964, focused attention on societal needs and led directly to introduction of the legislation authorizing Regional Medical Programs. Many of the Commission's recommendations were significantly altered by the Congress in the legislative process, but The Act was clearly passed to meet needs and problems identified and given national recognition in the Commission's report and in the Congressional hearings preceding passage of The Act. Some of these needs and problems were expressed as follows:

- A program is needed to focus the Nation's health resources for research, teaching and patient care on heart disease, cancer, stroke and related diseases, because together they cause 70 percent of the deaths in the United States.
- A significant number of Americans with these diseases die or are disabled because the benefits of present knowledge in the medical sciences are not uniformly available throughout the country.
- There is not enough trained manpower to meet the health needs of the American people within the present system for the delivery of health services.
- Pressures threatening the Nation's health resources are building because demands for health services are rapidly increasing at a time when increasing costs are posing obstacles for many who require these preventive, diagnostic, therapeutic and rehabilitative services.
- A creative partnership must be forged among the Nation's medical scientists, practicing physicians, and all of the Nation's other health resources so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions. They should similarly be provided the opportunity to participate in the academic environment of research, teaching and patient care which stimulates and supports medical practice of the highest quality.
- Institutions with high quality research programs in heart disease, cancer, stroke, and related diseases are too few, given the magnitude of the problems, and are not uniformly distributed throughout the country.
- There is a need to educate the public regarding health affairs. Education in many cases will permit people to extend their own lives by changing personal habits to prevent heart disease, cancer, stroke and related diseases. Such education will enable individuals to recognize the need for diagnostic, therapeutic or rehabilitative services, and to know where to find these services, and it will motivate them to seek such services when needed.

During the Congressional hearings on this bill, representatives of major groups and institutions with an interest in the American health system were heard, particularly spokesmen for practicing physicians and community hospitals of the Nation. The Act which emerged turned away from the idea of a detailed Federal blueprint for action. Specifically, the network of "regional centers" recommended earlier by the President's Commission was replaced by a concept of "regional cooperative arrangements" among existing health resources. The Act establishes a system of grants to enable representatives of health resources to exercise initiative to identify and meet local needs within the area of the categorical diseases through a broadly defined process. Recognition of geographical and societal diversities within the United States was the main reason for this approach, and spokesmen for the Nation's health resources who testified during the hearings strengthened the case for local initiative. Thus the degree to which the various Regional Medical Programs meet the objectives of the Act will provide a measure of how well local health resources can take the initiative and work

together to improve patient care for heart disease, cancer, stroke and related diseases at the local level.

The Act is intended to provide the means for conveying to the medical institutions and professions of the Nation the latest advances in medical science for diagnosis, treatment, and rehabilitation of patients afflicted with heart disease, cancer, stroke, or related diseases—and to prevent these diseases. The grants authorized by The Act are to encourage and assist in the establishement of regional cooperative arrangements among medical schools, research institutions, hospitals, and other medical institutions and agencies to achieve these ends by research, education, and demonstrations of patient care. Through these means, the programs authorized by The Act are also intended to improve generally the health manpower and facilities of the Nation.

In the two years since the President signed The Act, broadly representative groups have organized themselves to conduct Regional Medical Programs in more than 50 Regions which they themselves have defined. These Regions encompass the Nation's population. They have been formed by the organizing groups using functional as well as geographic criteria. These Regions include combinations of entire states (e.g. the Washington-Alaska Region), portions of several states (e.g. the Intermountain Region includes Utah and sections of Colorado, Idaho, Montana, Nevada and Wyoming), single states (e.g. Georgia), and portions of states around a metropolitan center (e.g. the Rochester Region which includes the city and 11 surrounding counties). Within these Regional Programs, a wide variety of organization structures have been developed, including executive and planning committees, categorical disease task forces, and community and other types of subregional advisory committees.

Regions first may receive planning grants from the Division of Regional Medical Programs, and then may be awarded operational grants to fund activities planned with initial and subsequent planning grants. These operational programs are the direct means for Regional Medical Programs to accomplish their objectives. Planning moves a Region toward operational activity and is a continuing means for assuring the relevancy and appropriateness of operational activity. It is the effects of the operational activities, however, which will produce results by which Regional Medical Programs will be judged.

On November 9, 1967, the President sent the Congress the *Report on Regional Medical Programs* prepared by the Surgeon General of the Public Health Service, and submitted to the President through the Secretary of Health, Education, and Welfare, in compliance with the Act. The *Report* details the progress of Regional Medical Programs and recommends continuation of the Programs beyond the June 30, 1968, limit set forth in The Act. The President's letter transmitting the *Report* to the Congress was at once encouraging and exhortative when it said, in part: "Because the law and the idea behind it are new, and the problem is so vast, the program is just emerging from the planning state. But this report gives encouraging evidence of progress—and it promises great advances in speeding research knowledge to the patient's bedside." Thus in the final seven words of the President's message, the objective of Regional Medical Programs is clearly emphasized.

Chapter II

THE NATURE AND POTENTIAL OF REGIONAL MEDICAL PROGRAMS

Goal—Improved Patient Care

Chapter I places the Goal of Regional Medical Programs in its historical context and gives a fuller perspective to Section 900 of the Act (see Appendix I), which defines the Goal in detail. In abbreviated form, the Goal is described in the Surgeon General's *Report* as ". . . clear and unequivocal. The focus is on the patient. The object is to influence the present arrangements for health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke, and related diseases to be available to all."

Means—The Process of Regionalization

Note: Regionalization can connote more than a regional cooperative arrangement, but for the purpose of *Guidelines,* the two terms will be used interchangeably. The Act uses "regional cooperative arrangement," but "regionalization" has become a more convenient synonym.

A regional cooperative arrangement among the full array of available health resources is a necessary step in bringing the benefits of scientific advances in medicine to people wherever they live in a Region they themselves have defined. It enables patients to benefit from the inevitable specialization and division of labor which accompany the expansion of medical knowledge because it provides a system of working relationships among health personnel and the institutions and organizations in which they work. This requires a commitment of individual and institutional spirit and resources which must be worked out by each Regional Medical Program. It is facilitated by voluntary agreements to serve, systematically, the needs of the public as regards the categorical diseases on a regional rather than some more narrow basis.

Regionalization, or a regional cooperative arrangement, within the context of Regional Medical Programs has several other important facets:

- It is both functional and geographic in character. Functionally, regionalization is the mechanism for linking patient care with health research and education within the entire region to provide a mutually beneficial interaction. This interaction should occur within the operational activities as well as in the total program. The geographic boundaries of a region serve to define the population for which each regional program will be concerned and responsible. This concern and responsibility should be matched by responsiveness, which is effected by providing the population with a significant voice in the regional program's decision-making process.
- It provides a means for sharing limited health manpower and facilities to maximize the quality and quantity of care and service available to the region's population, and to do this as economically as possible. In some instances, this may require inter-regional cooperation between two or among several regional programs.
- Finally, it also constitutes a mechanism for coordinating its categorical program with other health programs in the region so that their combined effect may be increased and so that they contribute to the creation and maintenance of a sys-

tem of comprehensive health care within the entire region.[1]

Because the advance of knowledge changes the nature of medical care, regionalization can best be viewed as a continuous process rather than a plan which it totally developed and then implemented. This process of regionalization, or cooperative arrangements, consists of at least the following elements: involvement, identification of needs and opportunities, assessment of resources, definition of objectives, setting of priorities, implementation, and evaluation. While these seven elements in the process will be described and discussed separately, in practice they are interrelated, continuous and often occur simultaneously.

Involvement—The involvement and commitment of individuals, organizations and institutions which will engage in the activity of a Regional Medical Program, as well as those which will be affected by this activity, must underlie a Regional Program. By involving in the steps of study and decision all those in a Region who are essential to implementation and ultimate success, better solutions may be found, the opportunity for wider acceptance of decisions is improved, and implementation of decisions is achieved more rapidly. Other attempts to organize health resources on a regional basis have experienced difficulty or have been diverted from their objectives because there was not this voluntary involvement and commitment by the necessary individuals, institutions and organizations. The Act is quite specific to assure this necessary involvement in Regional Medical Programs: it defines, for example, the minimum composition of Regional Advisory Groups.

The Act states these Regional Advisory Groups must include "practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program and members of the public familiar with the need for the services provided under the program." To ensure a maximum opportunity for success, the composition of the Regional Advisory Group also should be reflective of the total spectrum of health interests and resources of the entire Region. And it should be broadly representative of the geographic areas and all of the socio-economic groups which will be served by the Regional Program.[2]

Identification of Needs and Opportunities—A Regional Medical Program must identify the needs regarding heart disease, cancer, stroke and related diseases within the entire Region. Further, these

[1]It is not the intent of a Regional Medical Program grant to supplant either Federal or non-Federal sources of support for various activities related to achieving its purpose. Rather, the Regional Medical Program provides an opportunity to introduce activities which draw upon and effectively link activities already supported, or supportable in the future, through other sources. Current examples of other Federal programs that provide essential inputs into the health resources of the Region are: other activities of the National Institutes of Health, particularly the National Heart Institute, National Cancer Institute, and National Institute of Neurological Diseases and Blindness; other constituents of the Department of Health, Education, and Welfare particularly the Comprehensive Health Planning and Services Program in the Office of the Surgeon General, the Bureau of Disease Prevention and Environmental Control, the Bureau of Health Manpower, the Bureau of Health Services, the Social Security Administration, the Office of Education, and the Social and Rehabilitation Service; and other Government agencies, particularly the Office of Economic Opportunity, the Model Cities Program of the Department of Housing and Urban Development, and the Veterans Administration. New sources of possible support for activities related to a Regional Medical Program should be considered during both the planning and operational phases.

needs must be stated in terms which offer opportunities for solution.

This process of identification of needs and opportunities for solution requires a continuing analysis of the problems in delivering the best medical care for the target diseases on a regional basis, and it must go beyond a generalized statement to definitions which can be translated into operational activity. Particular opportunities may be defined by: ideas and approaches generated within the Region, extension of activities already present within the Region, and approaches and activities developed elsewhere which might be applied with the Region.

Among various identified needs there also are often relationships which, when perceived, offer even greater opportunities for solutions. The danger of "project vision," which is akin to tunnel vision, must be guarded against.

In examining the problem of coronary care units throughout its Region, for example, a Regional Program may recognize that the more effective approach would be to consider the total problem of the treatment of myocardial infarction patients within the Region. This broadened approach on a regional basis enables the Regional Program to consider the total array of resources within its Region in relationship to a comprehensive program for the care of the myocardial infarction patient. Thus, what was a concern of individual hospitals about how to introduce coronary care units has been transformed into a project or group of related projects with much greater potential for effective and efficient utilization of the Region's resources to improve patient care.

Assessment of Resources—As part of the process of regionalization, a Region must have continuously updated inventory of existing resources and capabilities in terms of function, size, number and quality. Every effort should be made to identify and use existing inventories, filling in the gaps as needed, rather than setting out on a long, expensive process of creating an entirely new inventory. Information sources include state and local health planning agencies, hospital and medical associations, and voluntary agencies. The inventory provides a basis for informed judgments and priority setting on activities proposed for development under the Regional Program. It can also be used to identify missing resources—voids requiring new investment—and to develop new configurations of resources to meet needs.

Definition of Objectives—A Regional Program must be continuously involved in the process of setting operational objectives to meet identified needs and opportunities. Objectives are interim steps toward the Goal defined at the beginning of this Chapter, and achievement of these objectives should have an effect in the Region felt far beyond the focal points of the individual activities. This can be one of the greatest contributions of Regional Medical Programs. The completion of a new project to train nurses to care for cancer patients undergoing new combinations of drug and radiation therapy, for example, should benefit cancer patients and should provide additional trained manpower for many hospitals in the Region. But the project also should have challenged the Region's nursing and hospitals communities to improve the continuing and in-service education opportunities for nurses within the Region.

Setting of Priorities—Because of limited manpower, facilities, financing and other resources, a Region must assign some order of priority to its objectives and to the steps to achieve them. Besides the limitations on resources, factors to consider include: 1) balance between what should be done first to meet the Region's needs, in absolute terms, and what can be done using existing resources and competence; 2) the potentials for rapid and/or substantial progress toward the Goal of Regional Medical Programs and progress toward regionalization of health resources and services; and 3) Program balance in terms of disease categories and in terms of emphasis on patient care, education and research.

(INTRODUCTORY MATERIAL)

I. CAN A SYSTEM OF NATIONAL PRIORITIES BE REFLECTED IN REGIONAL MEDICAL PROGRAMS?

In opening the discussion, Doctor Hogness suggested that primary consideration would have to be given not only to identification of the broad national goals for Regional Medical Programs, but to some consensus among national experts as to the best ways of accomplishing the goals. This would enable the Council to assign the highest priorities to the activities within individual Regional Medical Programs which move Programs along those lines. Grant applications would then be considered to reflect entire RMPs and judgements on them based on the 'Whole Program's ability to (1) affect the system of patient care, (2) improve the rendering of primary care, (3) be concerned with prevention of disease, (4) contribute to the continuing education of existing manpower and the training of new manpower, etc."

There was agreement among the members of the Council that any priority system designed for Regional Medical Programs should have its primary emphasis on methods rather than aims; which are "easily stated and rhetorical" and in the last analysis common to all efforts in medical care — the alleviation of the effects of disease.

Council also recognized that in beginning to look to priorities based on the suggestions of Doctor Hogness and others, it would be necessary immediately for them to recognize these priorities in their review and analysis and final recommendation on the funding of Regional Medical Program grants. Progress in priority development would then need to be shared with the Review Committee, site visitors, panel members, and other consultants who participate in the review process; and the guidelines made known to the staffs and Regional Advisory Groups of the 55 Regional Medical Programs. (MORE)

...August 26-27, 1969 Council Minutes

There was essential agreement that reallocation could have a favorable effect only if priorities can be agreed upon for administration of the program. Doctor Pellegrino suggested the following five steps toward accomplishing these ends: (1) Each new initial request should be examined carefully to determine whether or not it will improve cooperative arrangements in the Region. (2) Careful attention should be given to the progress of Regional Medical Programs and their component projects when they are reviewed for renewal. (3) Requests for purchase of major hardware should be closely examined, eliminating all but those which are absolutely essential and for which no other source of funding is available. (4) Attempt should be made to increase, whenever possible, the concentration of program effort on the specifically related categorical disease. (5) Care should be taken to identify project activities which can serve as models and to avoid unnecessary duplication of these models among and within individual Regions.

...December 16-17, 1969 Council Minutes (MORE)

(INTRODUCTORY MATERIAL)

There is agreement on the part of all members that the Council must continue to accept responsibility for setting broad National priorities for the program. They recognize the growing importance of the development of an arrangement by which they can assess the progress of individual Regions in implementing these priorities and in actually affecting the patterns of delivery of care in the areas they serve.

Doctor Brennan expressed another approach to the matter of program priorities. He viewed the most successful Regions as being those which have developed effective core staff and operational mechanisms which are bringing about change whether or not the changes are those "authorized" in the law. He suggests that two kinds of "technology" must be employed: (1) the translation of "new advances in health care" into "improved resources for health care;" and (2) the use of those resources to bring about actual improvement in care. He used as an example the control of cervical cancer in a certain geographic area. He stated that by the application of new advances we know "how" to control the disease, but that we still do not know exactly what are the costs and effects of various approaches to the use of this knowledge. It is his opinion that the development of this second "technology" is an important RMP function.

As a possible point of departure for the deliberations of this group, Doctor Everist offered a series of four priorities which he follows in considering Regional Medical Programs: (1) The quality of the core program - the personal qualification of the staff members; their capability of developing and handling information between and among the core staff, the cooperating agencies in the Region, and the national level; (2) the effectiveness of the core program - which he believes can be judged almost solely on the extent, effectiveness, and permanence of the cooperative arrangements which are developed and developing; (3) the accessibility of the core program - its responsiveness to needs for services and the degree of regionalization of services by means of RMP project monies and otherwise; and (4) the capacity of the core program - to be judged by the continuing enlargement of the system of both care and information in the Region.

NOTE: Above are exerpts from December 16-17, 1969 Council Meeting Minutes

Evaluation—Each planning and operational activity of a Region, as well as the overall Regional Program, should receive continuous, quantitative and qualitative evaluation wherever possible. Evaluation should be in terms of attainment of interim objectives, the process of regionalization, and the Goal of Regional Medical Programs.

Objective evaluation is simply a reasonable basis upon which to determine whether an activity should be continued or altered, and ultimately, whether it achieved its purposes. Also, the evaluation of one activity may suggest modifications of another activity which would increase its effectiveness.

Evaluation implies carrying out whatever is feasible within the state of the art and appropriate for the activity being evaluated. Thus, evaluation can range in complexity from simply counting numbers of people at meetings to the most involved determination of behavioral changes in patient management.

As a first step, however, evaluation entails a realistic attempt to design activities so that, as they are implemented and finally concluded, some data will result which will be useful in determining the degree of success attained by the activity.

Criteria—Evaluation of Regional Medical Programs—The criterion for judging the success of a Region in implementing the process of regionalization is the degree to which it can be demonstrated that the Regional Program has implemented the seven essential elements discussed in this Chapter: involvement, identification of needs and opportunities, assessment of resources, definition of objectives, setting of priorities, implementation, and evaluation.

Ultimately, the success of any Regional Medical Program must be judged by the extent to which it can be demonstrated that the Regional Program has assisted the providers of health services in developing a system which makes available to everyone in the Region improved care for heart disease, cancer, stroke, and related diseases.

(INTRODUCTORY MATERIAL)

Council, by voice vote, adopted the motion:

> The National Advisory Council to the Regional Medical Programs will interest itself in policy formulation for all HSMHA health service programs without altering its primary concern for the Regional Medical Programs.
>
> ...November 9-10, 1970 Council Minutes

Council passed by voice vote, with three abstentions and dissent, the motion:

> Council requests the Regional Medical Programs Service to communicate to Coordinators and Advisory Groups of Regional Medical Programs assurance of Council's continued interest in improving the quality of care delivered by all health personnel.
>
> .. November 9-10, 1970 Council Minutes

General Principles

Needs of the People and Vendors of health care: Regional Medical Programs do not have authority or funds to meet all felt needs for health services to the people or for sustained services to the ~~vendors~~ providers of health care by direct intervention. Regional Medical Programs are to concentrate on those needs for which voluntary participation by the ~~vendors~~ providers in regionalization can affect improvement. Priority ranking of projects in a Regional Medical Program is to be influenced most importantly by the amount of benefit obtainable for the service population per dollar of Regional Medical Program investment.

Long term support of services: Regional Medical Programs do not have authority or funds for support of services. Each operational project is to be designed to be integrated into the health care system of its Region, and to be disengaged from Regional Medical Program funding at the end of its initial project period of three years or less. Projects in operation that are failing to disengage from Regional Medical Program support by the ends of their third years may be allowed a reasonable period in which to become self-supporting or be terminated. Council recommends no more than 18 to 24 months as a "reasonable period" but refrained from setting a maximum which might tend to become a customary period.

Pick-up of projects formerly supported from other grant funds: Council reaffirmed its earlier recognition that Regional Medical Program funds are not intended to replace grants lost through discontinuance or reduction of other grant programs. Service or training projects inititated under other programs may be considered for Regional Medical Program support only to the extent that they: (a) respond to recognized need for local regionalization and improvement; and (b) demonstrate that they are integrating into the Region's health care system in a way that will permit disengagement of Regional Medical Program funding within a short time.

All above from November 9-10, 1970 Council Minutes

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STATUATORY AUTHORITY

STATUATORY AUTHORITY

...Legislative History

...Copy of current legislation (PL 91-515)

...Regulations

...Eligible Applicant

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REGULATIONS

REGIONAL MEDICAL PROGRAMS

March 18, 1967

Division of Regional Medical Programs
National Institutes of Health
Public Health Service
Department of Health, Education and Welfare

NOTE: Update per PL 91-515

I. Eligible Applicant

Public or nonprofit private universities, medical schools, research institutions and other public or nonprofit private agencies and institutions are eligible to apply for a grant to plan and/or operate a Regional Medical Program. Each applicant must be authorized to represent the agencies and institutions which propose to cooperate in planning for and development of the Regional Program. Additionally, each applicant must be able to exercise program coordination and fiscal responsibility (see agreement of affiliation, Chapter III, p. 14). Finally, each applicant in order to be eligible must have designated a Regional Advisory Group to advise the applicant (and those agencies and institutions which propose to cooperate in the Regional Medical Program) in the planning and operation of the Program.

It may be necessary for the agencies and institutions proposing to cooperate in the Program to create a nonprofit corporation to act for them as the applicant, to maximize the extent to which effective program and fiscal coordination can be exercised in the implementation of the Regional Program.

CHAPTER III - REVISED GUIDELINES - Page 8 *

Single Grantee—In order to insure regional cooperation, there can be only a single grantee organization for each Regional Medical Program.

CHAPTER III - REVISED GUIDELINES - Page 13

* Up-date per PL 91-515

II. Types of Grants

Planning—Section 903 of The Act authorizes the Surgeon General, upon recommendation of the National Advisory Council on Regional Medical Programs, to make grants to assist in the planning and development of Regional Medical Programs.

Operational—Section 904 of The Act authorizes the Surgeon General, upon recommendation of both the Regional Advisory Group and the National Advisory Council on Regional Medical Programs, to make grants to assist in the establishment and operation of Regional Medical Programs.

The planning activities which are initially funded under the provisions of Section 903 may be continued and expanded as an integral part of the operational activities of each Region and as such may become a part of the Region's operational grant under Section 904. However, operational activities may not be supported from planning grant funds.

Recognizing the necessity for each Region to plan ahead, the various Regional Medical Programs are encouraged to consider their phasing according to the nature and extent of the activities involved up to a maximum of five years.

The commitment for support beyond June 30, 1969, is based upon anticipated renewal of the Regional Medical Program's authorizing legislation and is predicated on the annual appropriation of funds by the Congress. Commitments beyond the terminal dates of legislation—both appropriations and authorizing legislation—are delimited by the phrase, "within the limits of available funds," written into the regulations and on the award statements issued by the Division.

NOTE: Up-date per PL 91-515

Project Grants for Multiprogram Services

Section 910 of the Act authorizes that funds appropriated under this title shall also be available for grants to any public or nonprofit agency or institution for services needed by, or which will be of substantial use to, any two or more Regional Medical Programs. Grant applications submitted under this section may be received from any Regional Medical Program or eligible institution or agency. If the application is for activities to be carried out in specific Regions, the approval of Regional Advisory Groups of all Regions covered by the proposed activity is required by the Division.

If the application is from an institution or agency seeking to provide services which may be utilized by two or more Regional Medical Programs, without a specific regional focus, Regional Advisory Group approval is not necessary. The application must include evidence documenting the need for the activity by two or more Regions, or show how the proposed service may be of use to two or more Programs. If a Regional Medical Program proposes to carry out such activity, the application must be approved by its Regional Advisory Group.

G 5.65

. communication device designed to speed the exchange of news, nformation and data on ional Medical Programs and related activities.

GUIDELINES for Multi-Program Services Project Grants - Regional Medical Programs Service

September 8, 1970 - Vol. 4, No. 36

A copy of GUIDELINES For Multi-Program Services Project Grants - Regional Medical Programs Service is attached. As noted in Section I ...

> "The addition of Section 910 to Public Law 90-574, the first extension of Public Law 89-239 which established Regional Medical Programs, provided a new grant authority designed to promote interregional cooperation and facilitate the funding of services needed by, or of substantial use to, any two or more Regional Medical Programs."

Since both the legislation for extension of Regional Medical Programs and the appropriations legislation for FY 1971 are still under consideration by the Congress, it is not possible to know the extent to which it will be possible to allocate grant funds for Multi-Program Services Project Grants; nor to specifically identify the "areas of national concerns, needs, and priorities" discussed under Purposes on page 2 in the Guidelines.

*The Regional Advisory Group should provide overall advice and guidance in the planning and operational Program, from the initial steps onward. It should be actively involved in the review and guidance and in the coordinated evaluation of the ongoing planning and operating functions. It should be constituted to encourage cooperation among the institutions, organizations, health personnel, and state and local health agencies such as the health planning bodies being established under the Comprehensive Health Planning Program, Public Law 89-749 as amended. It should be concerned with continuing review of the degree of relevance of the planning and operational activities to the objectives of the Regional Medical Program and particularly with the effectiveness of these activities in attaining the goal of improved patient care. The Advisory Group does not have direct administrative responsibility for the Program, but the clear intent of the Congress was that the Advisory Group would insure that the Regional Medical Program is planned and developed with the continuing advice and assistance of a group which is broadly representative of the health interests of the Region. The Advisory Group is expected to prepare an annual statement giving its evaluation of effectiveness of the regional cooperative arrangements established under the Regional Medical Program.

CHAPTER II - REVISED GUIDELINES - P 5

III. The Regional Advisory Group

The Act specifies that an applicant for a planning grant must designate a Regional Advisory Group. The Act also specifies that the Advisory Group must approve an application for an operational grant under Section 904. The Advisory Group must include practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, other health professions, voluntary health agencies, and representatives of other organizations, institutions, and agencies, and members of the public familiar with the need for the services provided under the Program. It should also be broadly representative of the geographic area and of the social groups who will be served by the Regional Medical Program.

The Regional Advisory Group should provide overall advice and guidance to the grantee in the planning and operational program from the initial steps onward. It should be actively involved in the development of the Regional objectives, as well as the review, guidance, and coordinated evaluation of the ongoing planning and operating functions. It should be constituted to encourage cooperation among the institutions, organizations, health personnel, state and local health agencies. It should be concerned with continuing review of the degree of relevance of the planning and operational activities to the objectives of the Regional Medical Program and particularly with the effectiveness of these activities in attaining the objective of improved patient care. Therefore, Advisory Group members should be chosen who will provide a broad background of knowledge, attitudes and experience.

To serve these purposes, the Advisory Group should operate under established procedures which insure continuity and appropriate independence of function and advice. It should formally consider what its specific duties and responsibilities shall be, including such things as the frequency of its meetings and appropriate methods for the replacing of retiring members.

The Advisory Group, through the grantee, must submit to the Division of Regional Medical Programs an annual statement giving its independent evaluation of effectiveness of the regional cooperative arrangements (regionalization) established under the Regional Medical Program.

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GRANTEE RESPONSIBILITIES

GRANTEE RESPONSIBILITIES

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...Early Termination of Grant

...Protection of Individual as Research Subject

...Animal Care

General Responsibilities—The grantee is obligated, both for itself and each affiliated institution, to administer the grant in accordance with regulations (Appendix 2) and policies of the Division of Regional Medical Programs. Where a policy is not stated or where the institutional policy is more restrictive than the Regional Medical Program policy, institutional policy prevails in that institution.

General Assurances—Specific attention is directed to the requirement to honor the assurances provided in the Act.

The recipient of a planning grant must comply with the assurances in Section 903 (b); namely:

- reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which awarded and in accordance with the applicable provisions of The Act and the regulations thereunder;
- reasonable assurances that the applicant will provide for such fiscal control and fund accounting procedures as are required by the ~~Surgeon General~~ to assure proper disbursement of and accounting for such Federal funds;

VA and minority group rep.

- reasonable assurances that the grantee will make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and
- a satisfactory showing that the applicant has designated an advisory group to advise the applicant (and the institutions and agencies participating in the resulting Regional Medical Program) in formulating and carrying out the plan for the establishment and operation of such Regional Medical Program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives from other organizations, institutions and agencies concerned with activities of the kind to be carried on under the Program and members of the public familiar with the needs for the services provided under the Program.

The recipient of an operational grant must comply with the assurances under Section 904 (b), namely:

- Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the Regional Medical Program with respect to which the grant is made;
- the applicant will provide for such fiscal control and fund accounting procedures as are required by the ~~Surgeon General~~ to assure proper disbursement of and accounting for such Federal funds;
- the applicant will make such reports, in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and
- any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pur-

NOTE: Up-date per PL 91-515

suant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

p 10

(Continued from CHAPTER III - REVISED GUIDELINES pg 9)

General Responsibilities--The grantee institution is responsible for administering the grant in accordance with regulations (Appendix 2) and policies of the Division of Regional Medical Programs. This responsibility applies both to itself and to each affiliated institution. When an affiliating institution does not have an officially stated or an applicable policy, then the grantee institution policy prevails.

For example, if an affiliating community hospital does not have salaried physicians who serve on a fulltime basis and thus has no applicable salary policy, then compliance with Division of Regional Medical Programs guidelines on salaries, as found in Chapter III, Section VII, page 14 (Allowable Direct Costs - A. Personnel Costs), would require use of the salary policies of the grantee institution.

Similarly, if an affiliating institution does not have an established travel policy, then the travel policies of the grantee prevail and, in any case, the general restrictions on travel policy apply, in accordance with Chapter III, Section VII, page 16 (Allowable Direct Costs - L. Travel).

ADDENDUM TO REVISED GUIDELINES - dtd 2/70 - Page 24

(Reference to Financial Mnagement)

GRANTEE RESPONSIBILITIES

"It is the fundamental responsibility of the Regional Medical Program grantee institutions to be responsible and primarily liable for the fiscal and administrative aspects of managing a Regional Medical Program. This means that grantees are held accountable for all funds awarded to them and the Federal Government will continue to hold that party fully accountable and responsible."

The Regional Medical Programs Service endorses the foregoing statement of policy, and urges the individual Regional Medical Program and its grantee institution to safeguard its own interest and rights of subrogation against affiliates either by a written contract or an agreement of affiliation between itself and affiliates.

Department of Health, Education, and Welfare attorneys have ruled that no authority currently exists whereby Regional Medical Programs Service or the Regional Medical Programs can vest title to equipment in affiliates at the time purchases are made. This decision was based on the principle that no privity exists between the Federal Government and institutions affiliated with grantees. Therefore, the option to vest title in these institutions is unavailable.

The Regional Medical Programs Service stands ready to assist Regional Medical Programs or grantee institutions in their understanding of the responsibilities under this policy. However, each Regional Medical Program and grantee is jointly responsible for insuring that its affiliated institution or organization is fully cognizant of the policies and procedures with respect to the expenditure of Federal funds.

NID 7-10-70

NOTE: Cross reference to Program Management (General Requirements).

GRANTEE RESPONSIBILITIES

Discrimination Prohibited—Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. Regulations implementing the statute have been issued as Part 80 of Title 45, Code of Federal Regulations. The Regional Medical Programs provide Federal financial assistance subject to the Civil Rights Act and the regulations.

It is the responsibility of the grantee to insure that each affiliated agency (institution) which proposes to cooperate in the Regional Medical Program is in compliance with Section 601 of Title VI of the Civil Rights Act of 1964. The grantee shall maintain a copy of the form which insures that each affiliated agency (institution) is in compliance.

Each grant for construction (alterations and renovation) is subject to the condition that the grahtee shall comply with the requirements of the Executive Order 11246, 30 F.R. 12319 and the applicable rules, regulations, and procedures as prescribed by the Secretary of Labor.

CHAPTER III -REVISED GUIDELINES - Pg 11

designed to speed the exchange of news, nformation and data on ional Medical Programs and related activities.

STATEMENT OF POLICY Re ....
~~Meetings~~ Supported with Regional Medical Program Funds

March 11, 1970 - Vol. 4, No. 12S

STATEMENT OF POLICY

Sponsors of educational activities funded by Regional Medical Programs may not permit discrimination against applicants on the basis of race, religion, place of employment, or origin of professional qualifications. Applicants to such activities should be selected, invited, or accepted only on the basis of academic or other objective qualifications set by the institution or organization responsible for the program.

ILLINOIS
REGIONAL
MEDICAL
PROGRAM
Heart Disease, Cancer, and Stroke
Office of the Executive Director
122 South Michigan Avenue • Room 939/Chicago, Illinois 60603/Telephone 312-939-7307

file Policy

April 15, 1970

Mr. Edward M. Friedlander
Assistant to the Director
Communications and Public Information
Regional Medical Programs Service
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

Dear Ed:

Regarding the "Statement of Policy re Meetings Supported with Regional Medical Program Funds," (Special Issue, Vol. 4, No.2S), our Nursing Committee was quick to point out that the statement makes no reference to discrimination on the basis of age or sex.

Since these are two particularly touchy areas for certain groups, it would be wise to include these categories in the policy statement.

We would appreciate your attention to this matter.

Yours truly,

Marilyn Voss

Marilyn J. Voss
Public Information
Assistant

MJV:bd

Change in Approved Program—The Division of Regional Medical Programs does not intend to interfere with administrative or program flexibility which serves the objectives of the Regional Medical Programs. If, however, a change is determined by the grantee to be desirable, and if that change would constitute a substantial change in the nature of the Program originally approved, the grantee must consult with the Division of Regional Medical Programs, staff. No substantial change in the approved Program can be made without the specific written approval of the Division of Regional Medical Programs. Requests for such approval must be submitted in an *Application for Revision* (page 21).

Change in Program Period—The Program period may be extended up to 12 months without additional funds, if requested by the grantee before the end of the Program period.

Change of Program Coordinator—A change of Program Coordinator or other key official directing the Program requires the written approval by the Division of Regional Medical Programs. Notification to the Division of Regional Medical Programs of such a proposed change must be signed by at least one of the two persons who signed the original application or their successors. A curriculum vitae for the newly appointed official should accompany the notification of change.

Change of Grantee Organization—If for any reason the grantee organization proposes to relinquish its reponsibility for a Regional Medical Program grant, it must immediately notify the Division of Regional Medical Programs. For example, a region may wish to create a non-profit corporation especially for the purpose of becoming the grantee organization. Any change of grantee organization requires that a terminal progress report, an expenditures report, and an invention statement (PHS-3945) be submitted to the Division of Regional Medical Programs.

If the grantee terminates its responsibility for the Regional Medical Program, the new institution/corporation must submit a new grant application for the remainder of the program period. The application should include the reasons for transferring the Program and the probable effect of the move on the Regional Program. Administrative approval may be given by the Division of Regional Medical Programs to continue the Program with a new grantee. Applications, however, that reflect major Program changes will be referred to the National Advisory Council on Regional Medical Programs for recommendation.

Early Termination of Grant—(1) By the Grantee—A grant may be terminated or cancelled at any time by the grantee upon written notification to the Division of Regional Medical Programs stating the reasons for termination.

(2) By the Public Health Service—A grant in whole or in part, may be revoked or terminated by the Surgeon General at any time within the program period whenever it is determined that the grantee has failed in a material respect to comply with the terms and conditions of the grant.

PROTECTION OF INDIVIDUALS AS RESEARCH SUBJECTS

"Nothing in the institutional assurance mechanism should inhibit PHS staff, advisory groups, or consultants from (1) identifying concern for the welfare of human subjects, and communicating this concern to the grantee institutions, or (2) recommending disapproval of the application if the gravity of the hazards and risks so indicate. This provision applies even if the application or contract in question has been reviewed and approved by a mechanism at the grantee institution which has been accepted by the PHS."

(Above quote from a memo to Directors of NIH, HSMHA, and CPEHS., and discussed in a memo, dated 7/25/69 from Deputy Director, RMPS, to All Staff)

Institutional Assurance Involving Human Subjects—An application for a Regional Medical Program grant which includes investigations involving human subjects will not be accepted for review unless the Public Health Service has approved a plan (known as Institutional Assurance on Investigations Involving Human Subjects, Including Clinical Research and Investigations in the Behavioral and Social Sciences) for insuring that the institution conducting the research has complied with the Public Health Service policy concerning research involving human subjects.

It will be the responsibility of the grantee to insure that the individual affiliated institution (s) which will be involved in these investigations secure the approval from the Public Health Service and to provide a copy of the approval to the Division of Regional Medical Programs.

A copy of the Instructions for obtaining Public Health Service approval may be obtained by writing the Grants Review Branch, Division of Regional Medical Programs, National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20014. *

NOTE: Wording and address up-date

Surveys or Questionnaires—Surveys or questionnaires arising from and supported by a grant should include a positive statement clearly setting forth that the contents are in no way the responsibility of the Public Health Service. They should conform with Bureau of the Budget, Circular #A-40.

Publications—Grantees and/or their affiliated institutions may publish materials relating to their Regional Medical Program without prior review provided that such publications carry a footnote acknowledging assistance from the Public Health Service, and indicating that findings and conclusions do not necessarily represent the views of the Service.

Patents and Inventions—The Department of Health, Education, and Welfare regulations (945 F.R., Part 6 and 8) provide as a condition that all inventions arising out of the activities assisted by Public Health Service Grants must be promptly and fully reported to the Public Health Service. Any process, art or method, machine manufacture or improvement thereof, may constitute an invention if it is new and useful and would not have been obvious to a person having skill in the art to which it relates.

In order for the Public Health Service to carry out its responsibility under these patent regulations, it is essential that the Service be advised before awarding Government funds of any commitments or obligations made by the institutions or by the professional personnel to be associated with the activities carried on under the grant which would be in conflict with the inventions agreement. When submitting an application for a Regional Medical Program, the grantee must provide in letter form either:

a. a statement indicating no previous commitments or obligations have been made, or

b. a detailed explanation of such commitments or obligations where they do exist.

One such letter will suffice for the named grantee and all affiliated institutions receiving support under the grant. It is the responsibility of the institution named as the grantee on the application to ascertain the facts relating to patents and to report these on behalf of all affiliated organizations in the Regional Medical Program as well as to inform affiliated institutions of these responsibilities.

In subsequent years an annual invention statement form PHS-3945 must be filed whether or not an invention has occurred. Where there are no inventions to report, a single form PHS-3945 is all that is required for the institution named on the application as the grantee and for all affiliated institutions. Where there are inventions to report, a separate annual invention statement must be filed for each one. Here again, it is the responsibility of the grantee to report on behalf of itself and all other affiliated organizations in the Regional Medical Program. The Regional Medical Program grant for the next year will not be issued until the invention statement form PHS-3945 has been received by the Division of Regional Medical Programs.

Animal Care—Each person assigned or ap-

(MORE)

SECTION II - GENERAL REQUIREMENTS

PROGRAM MANAGEMENT

SECTION I ...INTRODUCTION

SECTION II ...GENERAL REQUIREMENTS (Responsibilities of Program Coordinator, Regional Advisory Group, By-Laws, Relationships to Grantee, to DHEW Regional Offices and other Federal agencies and programs; Reports Required; Public Announcements of Approved Grants, etc.)

SECTION III ...ELIGIBLE ACTIVITIES
- Definitions
- Specific Requirements
- Central Administration
- Research
- Demonstrations of Patient Care
- Categorical Relevance
- Continuing Education, Training and Manpower
- Multiprogram Services
- Exclusions

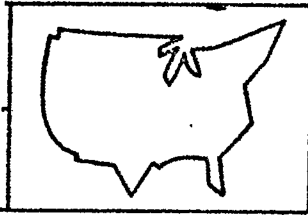
SECTION IV ...FINANCIAL MANAGEMENT

(List)

SECTION V ...PREPARATION AND SUBMISSION OF GRANT APPLICATIONS

(List)

service • news • information • data



communication device designed to speed the exchange of news, information and data on Regional Medical Programs and related activities.

Regional Medical Programs Service Representatives -- Department of Health, Education, and Welfare Regional Offices

October 30, 1970 - Vol. 4, No. 49S

Regional Medical Programs Service has named eight Representatives, and expects to name the remaining two in the near future, to the Department of Health, Education, and Welfare Regional Offices. (Listing on Pages 2 and 3.) It is expected that they will represent Regional Medical Programs Service, provide assistance to the individual Regional Medical Programs, participate in site visits for Program review, furnish information to Regional Medical Programs Service, and act as liaison with other Federal agencies.

In order to develop the best possible operating relationships, each Regional Medical Program is encouraged to provide its Representative with. . .

- A copy of each Program application, for review and comment, at the time it is submitted to the Grants Review Branch of Regional Medical Programs Service.
- Copies of correspondence between the Regional Medical Program and the staff of Regional Medical Programs Service.
- An invitation to attend the Regional Advisory Group meetings, as well as meetings of special and standing committees and selected staff meetings.

The staff of Regional Medical Programs Service is asked to provide the appropriate Regional Office Representative with . . .

- A copy of each grant award at the time it is mailed to the Program.
- Copies of correspondence concerning each Regional Medical Program for which he is responsible.

NOTE: Reference to DHEW Regional Offices.

(Exerpted from letter to Members of the National Advisory Council on Regional Medical Programs, dated November 4, 1970, signed by Vernon E. Wilson, M.D., Administrator, HSMHA)

5. RMPS staff has been assigned to each of the ten Regional Offices. That staff will not have direct responsibility for approval or disapproval of funding from a programmatic point of view, but will have very specific responsibility for fiscal assistance in carrying out the approved responsibilities in behalf of the National Office. This will primarily take the usual form of grants management.

Much of this emphasis is in an attempt to improve the communication link between the RMP Coordinator and the Regional Health Director who has responsibility for a wide variety of Federal health programs in the same geographic areas.

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

March 28, 1968

YOUR FILE REFERENCE:

IN REPLY REFER TO: 15

CHIEF MEDICAL DIRECTOR'S LETTER NO. 68-18

TO: Directors of Hospitals, Domiciliary, and VA Outpatient Clinics, and Managers of Regional Offices with Outpatient Clinics

SUBJ: Veterans Administration Participation in the Regional Medical Programs (RMP) of the Public Health Service

1. Purpose

The purpose of this letter is to clarify relationships between the Veterans Administration and the Regional Medical Programs (RMP) of the Public Health Service, and to provide implementing guidelines.

2. Background

The General Counsel's Office of the Department of Health, Education and Welfare has recently offered an opinion regarding the degree of participation of Federal facilities in Regional Medical Programs which now allows clarification of potential VA involvement in those programs. Title IX of the Public Health Service Act, "Education, Research, Training and Demonstrations in the fields of Heart Disease, Cancer, Stroke, and Related Diseases," (PL 89-239), is the basis for the establishment of the RMP. The purposes of the RMP will be effected via the grant mechanism. RMP grants are to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, hospitals, and other medical institutions and agencies--to make available the latest advances in the diagnosis and treatment of these diseases. Grant funds will support, through these cooperative arrangements, research, training (including continuing medical education) and related demonstrations of the highest standards of patient care. Through these means the Programs are intended to improve generally the health manpower and facilities of the Nation. (See Guidelines, Regional Medical Programs, DHEW, PHS, NIH, June 1967.)

(MORE)

Reports—All reports required to be submitted to the Public Health Service should be sent to the Division of Regional Medical Programs, Public Health Service, Bethesda, Maryland 20014.

A. Progress Reports—The grantee is required to submit an annual progress report for each grant. This report (s) should contain sufficient detail to inform the reader of the accomplishments with particular respect to the objectives and must be submitted with the application for continued support. In addition, grantees may be required to supply other information needed for guidance and development of the national program and are encouraged to report significant developments promptly at any time. A terminal progress report must be submitted to the Division of Regional Medical Programs within three months of the termination of the program period. Specifically, the report must describe the ways in which the process of regionalization as described in Chapter II has moved the Regional Program toward its goal of improved patient care for all those within the Region suffering from heart disease, cancer, stroke, or related diseases. The report must also include:

(1) principal staff members—names and positions

(2) organization of the Regional Medical Program

(3) membership and functions of the Regional Advisory Group

(4) names of all cooperating agencies/institutions and their relationship to the Regional Medical Program

(5) description of planning activities

(6) description of operational activities, if any

(7) description of interregional activities, if any

(8) the extent to which the planning and operational activities of the Program are supported by non-Federal funds.

B. Regional Advisory Group Reports—The Regional Advisory Group is expected to prepare an annual statement on the effectiveness of the regional cooperative arrangements (regionalization) established under the Regional Medical Program. The report, signed by the Chairman of the Regional Advisory Group, signifying its approval, should be submitted to the Division of Regional Medical Programs by the grantee along with the annual progress report. Periodic reviews of grants by the staff of the Division and the Advisory Council will include consideration of the effectiveness of the Advisory Group.

SUBJECT: Grant Announcements to Regional Medical Programs

In an effort to work out a better method for announcing grants to Regional Medical Programs that would be more mutually effective for both the appropriate Congressmen and Senators on the one hand, and the Regional Medical Programs on the other, Mrs. Dale Kohn of my staff and I met with Mr. Jerry Poole, Deputy Assistant Secretary for Congressional Liaison of the Department of Health, Education, and Welfare in his office on Wednesday, April 16.

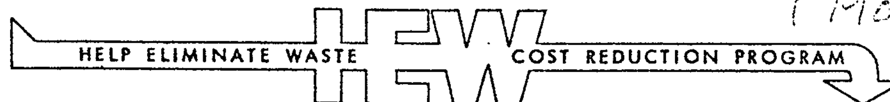
Mr. Poole demonstrated a very clear and sympathetic understanding of the problems reflected by the recent examples detailed in our memorandum to him of April 10. He agreed that a better system could and should be developed to meet the particular needs of the Division of Regional Medical Programs that would also help him fulfill his responsibility of helping to develop relationships between the Department and the members of Congress.

As a result, we have worked out the following new policies and procedures which include changes from the current method, painfully evolved over the past three years from the old National Institutes of Health-Public Health Service practice:

- Following establishment of the grant figures for an award to a Program by the Division, this office will contact the Coordinator and his authorized staff person in the office of the Regional Medical Program receiving the grant. In addition to providing them with the figures, we will encourage and work with them to develop appropriate releases and other informational materials in preparation for the announcement that will be made by the Congressional representatives of that Region, and to insure and safeguard that Congressional prerogative.

- For Regional Medical Programs purposes, the rule that requires only new grants to be reported to the Congressional Liaison Office will be ignored. In its place will be a judgment made by this office of which grants in terms of dollars and/or political significance are to be forwarded to the Department for reporting to the Congressional delegations.

(MORE)



ISSUES AND PROCEDURE: Re Public Announcement of Approved but Unfunded Projects

July 18, 1969 - Vol. 3, No. 28S

The following are the issues raised:

- Can these projects be publicly announced by the Programs as approved?
- How should the ultimate funding of these projects be announced, be it from reallocation of funds already announced from new funds to be granted, or from funds from other sources?
- What limitations or requirements are there on such announcements as related to members of Congressional delegations?

Because these types of notification can be expected to continue and these issues continue with them the following procedure has been established:

Announcements to special interested or involved Regional Medical Program publics, or to the general lay public of the Region, of the "conditional approval" of projects "favorably acted upon by the National Advisory Council" and " authorized for implementation" may be made by the Regional Medical Programs receiving such notification. However, these Programs are encouraged to use the foregoing quoted phrases (without quotes) along with the fact that no immediate funding is being made to support their projects, and future funding will be dependent upon the availability of sufficient funds. If appropriate, Program officials may detail their plans for either implementing these projects by rearranging other Regional Medical Program funds with Division of Regional Medical Program approval, or involving other funds to get these activities underway. Such announcements, regardless of the form or forms they may take, may be communicated to the appropriate Congressional delegations by the Program officials as a normal part of the total effort to keep the various publics concerned with the Regional Medical Program informed.

(General Requirements)

Miscellaneous—

(1) Safety Precautions—The Public Health Service assumes no responsibility with respect to accident, claims or illness arising out of any work undertaken with the assistance of a Public Health Service grant. The grantee institution is expected to take necessary steps to insure or protect itself and its personnel.

(2) Federal Income Tax—Determination of a tax status of an individual receiving compensation in any form from the Public Health Service grant is the responsibility of the Internal Revenue Service.

(3) Military Service—The Public Health Service will not intercede on behalf of an individual in relation to military status.

V. Eligible Activities

Categorical Emphasis—The focus of Regional Medical Programs under the authorizing legislation is on problems of heart disease, cancer, stroke and related diseases. This broad categorical approach must be a consideration in the development of specific Program elements under a Regional Medical Program. Because of the broad scope of heart disease, cancer, and stroke, it would be difficult and perhaps detrimental to some types of medical services and educational activities if a rigidly categorical approach were adopted for all relevant Program elements. The emphasis of the Program does require that the component elements be shown to have significance for combating heart disease, cancer, stroke and related diseases through a regional effort intended to improve the care of all those persons within the Region suffering from one of these diseases. However, in some instances, activities which have a more general impact extending beyond the specific problems of heart, cancer, stroke and related diseases may need to be supported because they are essential to the achievement of the purposes of Regional Medical Programs.

The objective of improved patient care for those suffering from these categorical diseases will require the full development of the process of regionalization, particularly in the Program's operational phases. Therefore, individual, categorical activities should be designed and implemented in ways which will insure their regional rather than organizational or institutional identity.

Core Support—The central administration and coordination of a Regional Medical Program represents the administrative heart of the Program, and as such is an activity eligible for grant support. The salaries of the Program Coordinator and his staff as well as other costs incident to the central administration and coordination of the Program may be charged to the grant.

Research—Research activities which are integral to the purposes and objectives of the Regional Medical Program are eligible for support and their costs may be paid by grant funds. Such research activities in order to be eligible must contribute to the process of regionalization and the goal of improved patient care the Program seeks to achieve.

(Definitions)

Demonstrations of Patient Care—Demonstrations of patient care may be supported when related to the objectives of the Regional Medical Program. The Act provides that the costs of patient care may be supported only when such care is incident to research, training, or demonstration activities encompassed by the purposes of the Program and only if the patient has been referred by a practicing physician. Documentation must be provided (see Chapter III, page 15). Such demonstrations must contribute to the process of regionalization and the goal of improved patient care which the Regional Program is seeking to achieve. Grant funds may be used to pay the other costs incident to the demonstration activity, including staff and equipment.

Training and Continuing Education—Continuing education and training programs for medical, allied health personnel and associated professions which are part of integrated comprehensive approaches of enhancing regional capability for the diagnosis and treatment of heart disease, cancer, stroke, and related diseases are eligible for support. However, it should be emphasized that the primary intent of the legislation in this area is the support of those activities that are beyond those normally accepted as basic preparation for work in the health field. If one is to make assessment of needs for educational programs, this assessment must be based on the system of health care, the role of the learner, and his needs. In medical education, attention must be focused directly on the questions: "Will this effort to change behavior result, in fact, in the patient receiving the maximum benefit of modern knowledge?". Grant funds may be used for innovative training approaches and the development of new types of health personnel or new arrangements of health personnel to meet the Region's goal of improved patient care for those suffering from heart disease, cancer, stroke, or related diseases.

NOTE: Up-date

"...The Council agreed that training was one of the most vital objectives of the Regional Medical Programs, and that there needed to be close collaboration with other programs in meeting the over-all manpower problem. Also considered were the support of full-time staff in the hospital for education and service purposes, the training of new types of medical manpower, the attraction of personnel to be trained...".

Council Minutes 2/24-25/66

Therefore the Council suggested that Regional Medical Programs...

- Actively work with metropolitan planning agencies and programs,
- Undertake appropriate patient care demonstration or other projects in inner-city areas,

and that the Division of Regional Medical Programs of the National Institutes of Health:..

- Encourage, develop, publish and promote a series of pertinent papers on subjects concerning relationships between Regional Medical Programs and urban problems,
- Name and call together appropriate national leaders to consider how the attention of Regional Medical Programs can best be focused on the urban health issues in metropolitan areas and their inner-cities.

YTD 9-29-67

Targeted for Specific Population Groups

"The Council, recognizing the diverse problems of medically disadvantaged consumer groups, both urban and rural, urges that specific planning to meet the health needs of such groups be a function of Regional Medical Programs.

"NOTE: In discussing this matter, the Council expressed its interest in further discussion of the special problems and appropriate role of Regional Medical Programs in metropolitan communities, especially in high density population areas served by many centers of medical excellence. Such an item will be placed on the agenda for the next meeting."

-- February 20-21, 1969 Council Meeting

VII. DIRECTED EFFORTS IN REGIONAL MEDICAL PROGRAMS

The, "Role of Regional Medical Programs in Urban Poverty Areas and Model Cities" was discussed. A request to earmark funds for Fiscal Year 1970 for Model Neighborhoods derives from the strategy adopted to relate Model Cities Programs not only to the funds directly available from the Department of Housing and Urban Development but to

identifiable funds from other Federal programs as well. The strategy adopted for RMP has been to encourage local generation of projects which strengthen cooperative arrangements. We recognize the Department's wish to identify funds for Neighborhood Model Cities, but believe the request to earmark the requested amount of $5-million from Regional Medical Programs is incompatable with the basic method of making grant awards in this program.

...November 25-26, 1968 Council Meeting

Model Cities Program

Model Cities is a major Federal response to the problems of the urban areas. It was established and is being implemented as a demonstration program to identify new ways in which Federal resources can be used more effectively. Model Cities is also viewed as a means of reforming Federal, state and local administrative systems through a partnership between government and private citizens from both the city involved and the affected neighborhoods. The legislation which established the concept requires that each city involved develop a program of sufficient innovation and magnitude to make a substantial impact on the physical and social problems of that city.

Regional Medical Program Involvement and Commitment

Since good health services are a basic societal need, the Health Services and Mental Health Administration has expressed its desire to coordinate its health planning and program development functions as represented by its agencies directly involved in this concern with the Model Cities programs. This action reflects the continued emphasis the Department of Health, Education, and Welfare is placing during fiscal year 1971 on the development and funding of new activities which will favorably affect persons living in Model Cities demonstration areas. Accordingly, $1.9 million in Regional Medical Programs grant funds will be earmarked for Model City related activities approved as part of regular Regional Medical Programs annual awards during fiscal year 1971.

New Certification Requirement and Process

In order to insure adequate participation by the offices of the mayors of the Model Cities and the Model City Demonstration Agencies (CDA) of these cities in the development of appropriate plans and activities, and to coordinate all such activity within the Health, Education, and Welfare Regions involved, a certification process has been developed, and is applicable to all Health, Education, and Welfare grant assistance programs, including those of Regional Medical Programs Service.

The newly established process requires written certification on a special form completed by each Director of a Model City Demonstration Agency certifying that each of the proposed activities or projects has involved acceptable citizen participation, is adequately linked with the total Model Cities Program, and that the sponsor has consulted on the project with a representative of the city's chief executive. The Health, Education, and Welfare Regional Director must also sign the certification document to indicate his knowledge and approval of the activity.

Radiation and Dosimetry Services

" In accordance with the recommendation of the Council in its February meeting, an Ad Hoc Committee on Radiotherapy Dosimetry Services was convened on April 8 to discuss the general subject of radiotherapy consultation and dosimetry services in Regional Medical Programs and to provide guidance to the Council for the review of proposals in this area. The following are the Committee's recommendations, which were approved by the Council, of what should be included in proposals asking support of radiotherapy consultation and dosimetry services:

- Indication of the applicant's intention to participate with representatives of other specialties involved, in a multi-disciplinary approach to the treatment of cancer patients.

- Assurance that the radiologists who are to receive the dosimetry service are adequately trained in radiotherapy or are willing to accept clinical consultation and assistance from the Radiotherapy Department providing the dosimetry service.

- Indication of measures to be taken to assure accurate record keeping, careful followup of each patient, continuity of care, and feedback of information on length and quality of survival.

- Assurance that there will be regular monitoring of all radiotherapy equipment, including calibration of the calibration instruments themselves.

- Indication of plans to make the dosimetry and calibration services self-supporting within a relatively short period of time."

-- May 26-27, 1969 Council Meeting

...Addendum to Revised Guidelines, 2/70, Pg 26-27

Registries: To date, only systematically operated cancer registries have yielded benefits that justified their operation. The benefits of registries of stroke patients, for example, are highly suspect because diagnosis is inaccurate. Similarly for other diseases, the funds required to operate registries could yield greater benefits if invested in preventive programs or in identification of hazards and risk factors. Well run cancer registries have provided data necessary for evaluation of treatment, continuing education and follow-up beneficial to patients. Multi-hospital registries also may offer side benefits to regionalization through the negotiation and cooperation involved in their planning, operation and distribution of information. Registries generally, like multi-phasic screening, hospital admission tests and examinations, and history-taking, are special forms of patient data acquisition. Council can muster little enthusiasm for perfunctory, under-utilized registries. On the other hand, it is felt that Regional Medical Programs should be enhancing applications of modern data handling to medical care in projects that meet other Regional Medical Program requirements.

Council decided that cancer and other registries, where the state-of-the-art permits, may qualify for Regional Medical Program assistance when: (a) They make important contributions to regionalized improvement of patient care; (b) planned to disengage Regional Medical Program funds promptly and (c) Regional Medical Program funding is confined to organization, planning of output, and development of new methods, and does not support major equipment purchases or operation.

Multiphasic Screening: Council sees multiphasic screening as a special form of patient data acquisition that has not yet demonstrated its value. Hypothetically, it could contribute importantly to health maintenance and other widely publicized new concepts in medical care, and to improved utilization of physicians and other shortage categories of health personnel. Council recognizes that many Regional Medical Programs are being pressed to support multiphasic screening. It is recognized also that the failure of multiphasic screening projects to demonstrate a positive cost-benefit ratio may be due as much to state-of-the-art problems as to problems of planning and execution. Council deferred action on two multiphasic screening project applications until the May 1971 meeting when there will be a report on the state-of-the-art -- with specific application to RMP. It was recommended, therefore, that a sub-committee of Council be appointed to investigate and obtain expert testimony, with staff assistance, on the state-of-the-art of multiphasic screening and similar forms of patient data acquisition.

Computer assisted dosimetry networks: Council reiterated its earlier findings with respect to dosimetry service systems. It was held that a dosimetry service should: (a) support itself, including equipment costs: (b) provide for consultation about the patient between the physician responsible for dosimetry and the physician(s) requesting the service; (c) require that equipment at the participating treatment stations be tested and calibrated regularly and systematically; (d) utilize Regional Medical Program funds only if it meets a recognized need for regionalization; and (e) confine expenditure of such funds to support of planning and organization.

NOTE: All above from November 9-10, 1970 Council Minutes

ELIGIBLE ACTIVITIES
(Specific Requirements)

Coronary care units: Council affirmed that although coronary care units are now established community resources Regional Medical Program funding units may be desirable when such units make important contributions to regionalized improvement in medical care, including overall efficiency and cost and when projects are planned to disengage from Regional Medical Program support promptly. To qualify for Regional Medical Program assistance, coronary care unit projects must also meet the following conditions: (a) An organizational structure and staff capable of implementing a high quality system must be present; (b) the mechanisms for entry into the system require development; and (c) RMP funding does not finance established technology, equipment, or patient service operations.

Training for coronary care units: Council requested RMPS to instruct all Regional Medical Programs having coronary care unit training projects to disengage Regional Medical Program funding at the ends of their current project periods or within a reasonable period thereafter, as noted above.

Mobile coronary care units: Experience with such units to date has demonstrated that initial costs are high, and experience to date has not developed capability to predict the degree of success that can be expected for given combinations of organization, staff, equipment, population and to assure geographic coverage and regional cooperation. In subjective comparison, it seems likely that the sum required to demonstrate a mobile unit program would produce greater benefits if invested in a well planned preventive program instead. Council asked RMPS to advise Regional Medical Programs to fund no new mobile coronary care projects.

...November 9-10, 1970 Council Minutes

NOTE: Cross-reference to Continuing Education, Training & Manpower

(CATEGORICAL RELEVANCE)

Disease Categorical Versus Comprehensive

"The Council reaffirms its endorsement of the policies in this regard as set forth in the Regional Medical Programs Guidelines Chapter III, Section V. However, in so doing, it emphasizes that full consideration will be given to applications for activities which pertain to problems in heart disease, cancer, stroke, and related diseases but which also have an impact on the diagnosis and treatment of other diseases, and/or fulfill a specified objective of the Region."

-- February 20-21, 1969 Council Meeting

In considering the matter of the "relevance" of component activities of any Regional Medical Program, the Council generally agreed with Doctor Millikan's statement that rather than being a matter of its direct relationship to one of the disease entities mentioned in Title IX, a project should be reviewed according to five basic considerations: (1) is it a valid scientific experiment; (2) is it a model for educational experience; (3) is it something other than a direct patient service; (4) will it open communications channels for improved local and Regional arrangements that will help to reach the long range goal of the Regional Medical Program; and (5) is it something that should be replicated in this or another Region? These questions were applied to the specific proposals and recommendations were arrived at accordingly.

Council Minutes 12/16-17/69

REASONS FOR SEPARATION OF BASIC AND CONTINUING EDUCATION WITHIN REGIONAL MEDICAL PROGRAMS AND EMPHASIS ON CONTINUING EDUCATION

Regional Medical Programs has emphasized in the past and continues to emphasize continuing education and training rather than basic education as a means of providing the opportunity "of making available to their patients the latest advances in the diagnosis and treatment of these diseases" for the following reasons:

- There still exists a lack of emphasis on continuing education as an important facet in the total educational development of health personnel.

- RMP provides a meaningful regional framework of cooperative activity into which continuing education programs can be incorporated. Continuing education can play a role in developing cooperative arrangements and, conversely, regional cooperative arrangements are essential to the development of continuing education programs.

- RMP, because of its focus on the practitioner and his effect on patient care as well as through its mechanism of "demonstrations of patient care," provides the ideal setting for the connection between acquisition and utilization of knowledge that is the key to the learning process in continuing education. It is the health care needs of his patients that dictate the continuing education needs of the health practitioner and it is his utilization of this continuing education that sets the quality level of his practice. RMP, therefore, has the opportunity to make continuing education relevant to its real purpose--that of improving the health care of people with heart disease, cancer, stroke and related diseases.

- As a result of specialization, sub specialization and the development of new technologies, the health establishment has proliferated so that there are now many different kinds of health professionals. A variety of medical care teams has resulted but continuing education remains largely unidisciplinary. The cooperative arrangements of regional medical programs can provide an excellent base for multidisciplinary interprofessional continuing education with its primary focus--the care of the patient with heart disease, cancer, stroke and related diseases.

- Generally speaking, other agencies exist whose primary efforts are aimed at supporting supply and training of health manpower at the basic and postgraduate level.

...Addendum to Revised Guidelines, 2/70
Pg 14-15

NOTE: Definitions?

II. Continuing Education and Training - Definitions

Section 900a of P.L. 89-239 authorizes Regional Medical Programs to use, as means of accomplishing its purposes, research and training (including continuing education) and related demonstrations of patient care. While the wording of the law is quite general, it is clear from the legislative history and other sources that the primary educational interest of Regional Medical Programs is in continuing education and training activities. As an operational definition of continuing education, the following has been accepted: "Those educational endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in the health related fields." Generally, activities should not be designed principally to qualify one for a degree, diploma, or board certification. In general, standard internship and residency programs would not qualify as "continuing education." Continuing education and training activities should lead to the assumption of new responsibilities in the already chosen career field; update knowledge and skill in the chosen career field, or add knowledge and skill in a different but basically related health field. Addendum to Revised Guidelines, 2/70, Pg 6

CONTINUING EDUCATION AND TRAINING - DEFINITIONS

The primary educational intent of Regional Medical Programs is in continuing education and training. As an operational definition of continuing education, the following has been accepted: "Those educational endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in a health related field." Continuing education activities must not be designed principally to qualify one for a degree, diploma or certification; therefore, internship and residency programs have been excluded from primary consideration. Training designed principally to prepare one for a research career in the biomedical sciences has also been excluded.

Continuing education and training activities should lead to the assumption of new responsibility in the already chosen career field, update knowledge and skills in the chosen career or add knowledge and skill in a different but basically related health field but not provide for career change. In general, therefore, interest is in task-oriented training. (Addendum to Revised Guidelines, 2/70, Pg 13)

We have further specified conditions which should be met by the continuing education or training activity submitted for funding:

(1) The activity must be shown to meet documented Regional needs.
(2) Evidence should be presented to show that such activities do not already exist or do not exist in sufficient number.
(3) An operational activity must have been approved by the regional advisory group.
(4) In accordance with the provisions of Section 904(b)(1)(B) of P.L. 89-239, the availability of other sources of funding must have been fully explored.
(5) The goal of the activity should be to maintain or improve the quality of practice of health professionals. In general, activities will fall into one of three categories:

 (a) Maintaining the level of practice of the health professional (e.g., refresher courses, seminars, conferences, etc.).
 (b) Improving the level of practice of the health professional (e.g., special training courses in coronary care, cancer therapy, etc.).
 (c) Developing new areas of interest for the health professional (e.g., training leading to the assumption of new responsibilities in a chosen career field, obtaining knowledge and skills in a different but basically related health field, the development of new types of health professionals, including, for example, the medical planner and administrator.

It is recognized, as stated in the revised Guidelines that "grant funds may be used for innovative training approaches and the development of new types of health personnel...." Such activities and others may require investment in basic training or education. Such activities will be judged on their merit and on the documentation by the Region of the need for such an activity.

Exclusions:

It should be emphasized that Regional Medical Program funds are not to be used to "supplant funds that are otherwise available for establishment or operation...." (Sec. 904(b) 1, P.L. 89-239). Therefore, generally excluded from funding is training designed specifically to prepare one for a research career in the biomedical sciences.

We urge Regional Medical Programs to become familiar with all available sources of support for education and training, including private as well as other Federal sources, e.g., the National Institutes of Health, the National Science Foundation, and the Department of Defense. It is to be expected that Regional Medical Programs will seek support or help cooperating agencies or institutions seek support for a wide variety of training and education activities, basic and continuing, from several different sources. In many instances, shared funding by a number of cooperating agencies will be appropriate. The Division of Regional Medical Programs may be of help in such cases.

CRITERIA FOR FUNDING *

The following criteria have been adopted for determining those continuing education activities most suitable for funding:

- The activity must be shown to meet documented Regional needs.
- Evidence should be presented to show that such activities do not already exist or do not exist in sufficient numbers.
- The goal of the continuing education activity must be to maintain or update knowledge and skill in order to improve the level of practice of the already qualified health professional.
- The activity must relate to the categorical nature of the program and be part of a comprehensive plan to enhance regional capability in the care of patients with heart disease, cancer, stroke and related diseases.
- RMP funding is not to be used to replace existing sources of support for educational activities.

...Addendum to Revised Guidelines, 2/70 Pg 13-14

*NOTE: See Pgs 6-7, Addendum to Revised Guidelines, 2/70

BASIC TRAINING OF ESTABLISHED ALLIED HEALTH PROFESSIONS

Definition

A health profession will be considered established if a Board of Schools AMA Council in Medical Education, or some similarly recognized mechanism, has been set up to approve schools, outline standards for admission, curriculum requirements and certification procedures and/or if definitive formal educational programs in the particular health occupation have already been instituted in the educational and training systems of hospitals, technical schools, junior and senior colleges.

Council recommends that no RMP grant funds be used for the cost of providing basic education and training in established allied health professions as defined above.

Regions are encouraged, however, to use professional staff assistance as well as direct support of special planning studies to encourage educational institutions in conjunction with clinical resources to provide new educational and training opportunities in established allied health disciplines and to add new disciplines.

...Addendum to Revised Guidelines, 2/70 Pg 16

BASIC TRAINING

As has been stated previously, support of basic education and training programs in the medical, allied and associated professions is not the primary "target" of RMP and is not, therefore, normally anticipated. The supply and basic training of manpower is more logically the "target" of other Federal agencies such as the Bureau of Health Professions Education and Manpower Training, Office of Education, and Department of Labor. However, because of the number of applications received by DRMP requesting basic training support in the allied health professions, Division staff divided these proposals into three categories, - health careers recruitment, basic training in "established" allied health professions and basic training for the development of new types of health personnel. The February, May and August Councils have taken these under consideration and made the following recommendations: *

...Addendum to Revised Guidelines, 2/70 Pg 15

NOTE: Item continues. (Definitions)

. Regional Medical Program Support of Recruitment and Basic Training of Health Personnel as Distinct from Continuing Education and Refresher Training

The Council reaffirms its position on this matter and offers the following criteria for interpretation of the definitions set forth in the current Regional Medical Programs Guidelines:

Certain criteria have been adopted for deciding whether or not an activity is to be considered as continuing education and training, e.g., activities must in general not be those designed principally to qualify one for a degree, diploma, or Board certification; therefore, internship and residency programs have been excluded from primary consideration. The education and/or training activity should lead to the assumption of new responsibility in the already chosen career field, or update knowledge and skill in a different but related health field. In general, therefore, interest is in task-oriented training.

Training designed principally as preparation for a research career in the biomedical sciences have been excluded. It has been stated that Regional Medical Program funding is not to be used to replace existing sources of support for educational

N/D 5-13-69 (More)

- The activity must satisfy a documented need of a Regional Medical Program, and must be shown to have a relatively high priority for funding.

- Other avenues of funding must have been explored and found inadequate either by the Region or by the Continuing Education and Training Branch of the Division of Regional Medical Programs. In many cases, funding is requested for projects because of a lack of available funds by other agencies such as the Bureau of Health Manpower.

- The Division of Regional Medical Programs or the Region itself must also explore the possibility of phasing out the Regional Medical Program funding as money becomes available from other sources. Other Federal agencies such as the Office of Education and the Department of Labor are beginning to support parts of recruitment and training activities affecting the health field.

- The Region or the Continuing Education and Training Branch of the Division of Regional Medical Programs must have explored the possibility of joint funding with other interested agencies.

- If the education and training activity has been shown to be necessary to achieving the purposes of a Regional Medical Program, and the above criteria have been met, then the proposed project may be approved for funding.

Basic Training of Allied Health Personnel

The Council recommends that Regional Medical Programs grant funds for basic training[1] of allied health personnel be limited as follows:

- For projects which meet the criteria for funding which are set forth in the Guidelines[2] and discussed further in the Council recommendations of February 1969[3]; and

- For training related to newly developed technologies or new modalities of diagnosis and treatment for which no standard curriculum is yet recognized and no minimum national standards for certification or licensure are yet established; and which is not generally part of the regular offerings of the health-related educational and training system of hospitals and/or technical schools, junior and senior colleges.

This restriction on use of Regional Medical Programs funds will be limited to the actual costs of provision of the training and for payment of student support and assistance.

Regions are encouraged to use both professional staff assistance and direct support of special planning studies to encourage educational institutions (technical institutes, public adult education resources, extension programs, junior and senior colleges, and hospitals) in conjunction with the resources for clinical experience, to provide new educational and training opportunities in the established allied health disciplines and to add new disciplines; but only after they are fully identified as essential to the provision of a recognized service to patients.

At the National level, the Division further proposes to encourage the incorporation of these disciplines into the various training and education systems, such as those which set standards, approve curricula, and aid in counselling and recruitment; as well as those which assist in the financing (Federal and non-Federal) of allied health career programs

In implementing this recommendation, the Division will ask the Council to consider the various disciplines separately and will base specific limitations on their judgment whether a discipline falls into the category described.

1/ Defined for purposes of Regional Medical Program grants as training required for a certificate, diploma, or degree, or which otherwise leads to the fulfillment of the experience and education requirements for initial entry into a health career.

2/ Guidelines, Supplement #1 - Expanded Statement on Education & Training, August 1968.

3/ News, Information and Data, Volume 3, Number 17S, May 13, 1969, National Advisory Council Speaks to Six Issues Re Components of Program Activities.

2. Identification of "established" allied health disciplines.

Following the suggestion of the Council at the May meeting, the staff proposed some further guidelines for development of projects to train allied health personnel.

The Council reaffirmed its previous position that use of Regional Medical Program funds for the actual costs of basic training and for student support be limited to "newly developed technologies or new modalities of diagnosis and treatment for which no standard curriculum is yet recognized and no minimum national standards for certification or licensure are yet established; and which is not generally part of the regular offerings of the health-related educational and training system of hospitals and/or technical schools, junior and senior colleges." This guideline was made more specific by the Council's decision to accept the staff's recommendation that an allied health profession will be considered established if a Board of Schools, American Medical Association Council on Medical Education, has been set up to approve schools, define standards for admission, curriculum requirements and certification procedures.

The three disciplines presented for specific consideration were Inhalation Therapy, Nuclear Medicine Technology, and Radiation Therapy Technology and it was agreed that all these would fall into the group for which basic training support would be denied.

...August 26-27, 1969 Council Minutes

NEW TYPES OF HEALTH PERSONNEL

Both the original and revised Guidelines state that "Grant funds may be used for innovative training approaches and the development of new types of health personnel or new arrangements of health personnel to meet the Region's goal of improved patient care for those suffering from heart disease, cancer, stroke or related diseases." Some of these activities may fall into the category of basic education.

Definition

The definition accepted by Council for the training of new types of health personnel is that training which relates to newly developing technologies or new modalities of diagnosis and treatment for which no standard curriculum is yet recognized and no minimum national standards for certification or licensure are yet established and which is not generally part of the regular offerings of the health-related educational and training system of hospitals and/or technical schools, junior and senior colleges.

Criteria for Funding

The training activity must satisfy a documented need of a Regional Medical Program, and must be shown to have a relatively high priority for funding.

...Addendum to Revised Guidelines, 2/70, Pg 16

3. Training of Physician Assistants

After consideration of the background materials which were requested by them and prepared and submitted by staff, the Council agreed that projects relating to the development of non-professional manpower to assist physicians in the direct care of patients (generally referred to as "physician's assistants") — including the direct costs of providing training and student support -- may be eligible for funding as part of Regional Medical Programs.

In making this recommendation, the Council emphasized that this action implied no relative priority for projects of this kind in the spectrum of Regional Medical Program activities, nor the priority of one approach to the training as related to another.

...August 26-27, 1969 Council Minutes

HEALTH CAREERS RECRUITMENT

The Council recognized the need for additional health manpower but because of the time span between recruitment and improved patient care, it recommended that further support of health careers recruitment projects with Regional Medical Program funds be granted only when a project is related to a clearly focused (specialized) short-range approach to the critical needs of a region, and

- Has the documented committed support not only of the sponsoring agencies, but of the Region's hospitals, schools, and colleges whose cooperation is essential for the success of the immediate project and its continuation after Regional Medical Programs support can no longer be made available;
- Includes a plan for evaluation of the impact of the program on the rate of production of trained health manpower;
- Is directed at special population groups, especially those who do not usually seek, or have available, opportunities for training or education beyond secondary school; *
- Other sources of funding have been explored.

*Sub-para graph expanded by correction to Addendum to Revised Guidelines 2/7

Health Manpower Recruitment

In recognition of the nationwide need for more and more competent allied health personnel, the Council reaffirms its policy of support for effective Regional Medical Programs activities directed toward meeting those needs. However, a direct relationship between specific recruitment efforts at the high school level and increases in qualified health personnel is difficult to demonstrate; and the real impact of a recruitment project on the care of patients is often remote or obscure. The Council, therefore, recommends that further support of such projects with Regional Medical Programs funds be granted only when a project is related to a clearly focused (specialized) short-range approach to the critical needs of a region, and

- Has the documented committed support not only of the sponsoring agencies, but of the Region's hospitals, schools, and colleges whose cooperation is essential for the success of the immediate project and its continuation after Regional Medical Programs support can no longer be made available;
- Includes a plan for evaluation of the impact of the program on the rate of production of trained health manpower;
- Is directed at special population groups, especially those who do not usually seek, or have available, opportunities for training or education beyond secondary school.

B. Cardiopulmonary Resuscitation Training Projects in Regional Medical Programs

The Council discussion was based on the material presented by staff and on its accumulated experience in reviewing Regional Medical Program applications which contain Cardiopulmonary Resuscitation training projects.

There was general agreement on the appropriateness and value of projects to provide training for selected groups of professional and allied health personnel in the techniques of cardiopulmonary resuscitation, as components of Regional Medical Programs, as determined by the level of priority assigned to such projects by individual Regional Medical Programs and their Regional Advisory Groups.

They were, however, unable to arrive at any consensus as to the real value of the almost unlimited extension of such training programs to non-medical personnel, particularly when relating the cost of such training (in dollars, facilities, and manpower) to the presently limited funds available for grants to carryout the purposes of Public Law 89-239 (Education, Research, Training, and Demonstrations in the Fields of Heart Disease, Cancer, Stroke, and Related Diseases).

...August 26-27, 1969 Council Minutes

> Regional Medical Program grant funding for projects in cardiovascular resuscitation training is to be limited to training activities which are directed principally to medical and allied health personnel who are employed in hospitals and in other in-patient facilities, or in out-patient or emergency facilities operated by or directly related to institutions in which follow-up care is immediately available.

Council Minutes 12/17-17/69)

THE FOLLOWING POLICY GUIDELINE was restated by the National Advisory Council, Regional Medical Programs Service, at the December 16-17, 1969 meeting. It had been adopted at the August 1969 meeting in regard to a group of pending projects:

Cardiopulmonary Resuscitation Training

"Regional Medical Program grant funding for projects in cardiovascular resuscitation training must be limited to activities which are directed principally to medical and allied health personnel. Such personnel must be employed in hospitals and other inpatient facilities, or in outpatient or emergency facilities operated by or directly related to institutions which can provide immediate followup care."

(Printed in Addendum to Revised Guidelines, 2/70)

Minutes of Meeting of National Advisory Council, Regional Medical Programs Service

Television Production and Network Facilities

" Council recommends that all new operational projects requesting major investments or funds for equipment and activities in television be thoroughly studied by Division staff and expert consultants for consideration for funding under the new authority for Multi-program Services provided under Section 910. It further recommends that applications for continuation and renewal of previously funded major television activities be reviewed by the same group of expert consultants on the basis of the progress being made in the applicant Region toward its television objectives, and how those activities might be related or expanded to a Multi-program Service."

-- February 20-21, 1969 Council Meeting

...Addendum to Revised Guidelines, 2/70, Pg 27

NOTE: Cross-reference to Multiprogram Services.

Dial Access Audiotape

"The technique of direct telephone access to pre-recorded tapes on selected topics of interest to physicians and allied health personnel is becoming increasingly popular in Regional Medical Programs. The Council recommends that proposals for projects of this kind meet the following criteria before being referred for review as part of a Regional Medical Programs application:

The application should contain an explanation of the way in which the project fits into the total regional education effort for physicians and other health professionals.

Proposed evaluation of the service must involve its receptivity and value to the professionals in their practice. The mere measurement of numbers of the incoming calls is insufficient.

When the request includes the establishment of an independent network (in contrast to sharing an already established facility), the statement of justification for the hardware investment should include the rationale for a new network as well as a plan for long-term use of the network.

There must be a plan (both long and short range) for the development of the tape library, justifying any decision to make rather than share or purchase tapes; for the selection of subject matter; and for the identification of target groups (i.e., physicians, nurses, etc.)."

-- May 26-27, 1969 Council Meeting

... Addendum to Revised Guidelines 2/70 Pg 25

V. Other Training Provisions

A. Citizenship:

The Division of Regional Medical Programs adheres to the policy which provides that only United States citizens and those foreign nationals having in their possession a visa permitting permanent residence in the United States may be appointed as trainees on training grants.

B. Long-Term Training Appointments:

A "Statement of Appointment of Trainee" (Form PHS 2271, PHS-3190-5, or PHS-4885-2 as appropriate) will continue to be required for each appointment or reappointment of a trainee receiving stipend, dependency allowance, tuition costs, or travel from a program supported by the Division of Regional Medical Programs' funds. For each appointment, or reappointment, the statement must be submitted at the time the training period of the individual begins. No obligation for trainee support may be made against grant funds until this statement is submitted.

If there are changes in the terms of the appointment (e.g., support period, stipend, supplementation, dependency allowance, tuition) an amended Statement of Appointment is required.

C. Reporting of Short-Term Training Programs:

Short-term training supported by the Division of Regional Medical Programs' funds will be reported in the aggregate on a regional basis. To be included in such a report are the number of trainees who participated, occupational categories represented, and the grouping of levels of academic preparation of the trainees.

POLICY ON KIDNEY DISEASE ACTIVITIES
ENDORSED BY NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

July 28 - 29, 1970

In recognition of the importance of chronic renal disease as one of the impairments of man, essentially related to heart disease, cancer, and stroke, the Regional Medical Programs Service, with the advice of the National Advisory Council and a number of recognized experts in the field of nephrology, offers the following guidelines to Regional Medical Programs for the planning and development of kidney disease activities as components of individual regional programs or as cooperative enterprises of two or more neighboring Regional Medical Programs.

Recognizing the competition for both funds and manpower in the further development of comprehensive kidney disease capabilities within the health care system, the Regional Medical Programs Service and the National Advisory Council will exert their best judgement in allocating the limited amount of funds available for this purpose in FY 1971 and 1972 to Regional Medical Programs which propose the investment of grant funds ---

- To encourage wider and more effective cooperative arrangements among selected institutions and resources which together can form comprehensive systems of care; and

- To strengthen existing institutional resources competent and willing to reach beyond the confines of the medical centers within which they exist for development of systems of services and training.

(MORE)

regional
medical
programs
service

communication device
designed to speed
the exchange of news,
nformation and data on
ional Medical Programs
and related activities.

ANNOUNCEMENT: Senior Clinical Traineeships in Cancer for Post-Residency Physicians

August 24, 1970 - Vol. 4, No. 19

The Senior Clinical Traineeship Program is now the responsibility of the Regional Medical Programs Service, as explained on Page 2 of this issue.

The center spread announces the latest information on this post-residency training program for physicians and provides the information for candidates who wish to apply for awards.

Please post, route or forward this publication for those who may be interested.

THE FOLLOWING RECOMMENDATION was made by the National Advisory Council, Regional Medical Programs Service, at its May 26-27, 1969 meeting. It supplements the preceding paper on Background Information and Amended Statements Concerning Continuing Education and Training:

Training of Cytotechnologists

"Upon recommendation of the Council, the Division has identified Cytotechnology as an established allied health discipline. Its training programs are approved by the American Medical Association Council on Education when properly recommended by the profession, and graduates are certified for practice by a nationally recognized examination administered by the profession. The techniques of exfoliative cytology are now of universally recognized value in screening and diagnosis of pathologic states.

Therefore, in line with general policy relative to support of established programs and in keeping with above policy guidelines on training, the Council recommends that Regional Medical Programs grant funds not be used for the costs of providing the basic education and training of cytotechnologists, either as a grant for an independent project or as part of a project demonstrating the application of exfoliative cytologic techniques to patient care."

...NID 5-13-69

NOTE: Cross reference to Eligible Activities (C.E.Tng & Mnpwr)

1. RMP funds should not be used to establish or otherwise support centers for the evaluation of methods of treatment of stroke patients, since sixteen such centers are funded under careful study by the National Institute of Neurological Disease and Stroke.

...March 31-April 1, 1970 Council Minutes

NOTE: Cross-reference to Demonstrations of Patient Care

SECTION IV - FINANCIAL MANAGEMENT

VII. Financial Management

General Requirements—Federal funds awarded pursuant to either a planning or operational grant are to be used only for the purposes for which awarded and in accordance with the provisions of the Act (Appendix 1), its regulations (Appendix 2), and these *Guidelines*. Additionally, Federal funds awarded pursuant to an operational grant may not be used to supplant funds that are otherwise available for the establishment or operation of the Regional Medical Program with respect to which the grant is made.

Funds granted may be used only for services, materials and other items required to carry out the approved program. Circular A–21 of the Bureau of the Budget should be used to the extent practicable in determining allowable costs related to the grants for Regional Medical Programs. Where the Division of Regional Medical Programs requires prior approval for items not listed in the approved budget, a written request must be made by the grantee to the Division of Regional Medical Programs in advance of the act which requires the obligating or expenditure of funds.

Agreement of Affiliation—By accepting a Regional Medical Program grant, the grantee has accepted certain responsibilities enumerated on pages 9–10 of this Chapter. However, the Regional Medical Program activities will necessitate the expenditure of grant funds by a number of different institutions, organizations, and agencies in addition to the grantee. In order to assure appropriate accountability for the expenditure of grant funds by these additional agencies, an Agreement of Affiliation must be signed by the responsible official of each affiliating institution (or agency) and by the grantee who represents the Regional Medical Program. Such an agreement will not be required nor appropriate in the conduct of business with (1) a profit-making organization by subcontract, or, (2) where direct payment is to be made for the use of facilities or for services rendered on behalf of the Regional Medical Program. This agreement, at a minimum, must include provision which will insure that the grantee can carry out the assurances required by the Act in Sections 903(b) and 904(b) and that the grant funds provided to each affiliated agency will be administered by that agency in accordance with the Act, the regulations and applicable policies of the Division of Regional Medical Programs (see example—Appendix 3).

The Division also encourages the Regional Medical Program to include in such agreement any provisions relating to the conduct and development of the Regional Medical Programs as may be appropriate and desirable for the achievement of the purposes of the Program as outlined in these *Guidelines*. The advice and counsel of the Regional Advisory Group should be sought in developing such provisions.

STATEMENT OF THE NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS ON SALARIES FOR KEY STAFF MEMBERS

The National Advisory Council on Regional Medical Programs has expressed concern about the possibility that salary levels being requested for the key staff of Regional Medical Programs may lead to escalation of salary levels among the Programs and may create difficulties in relationships within and among participating institutions in a region. This possibility is increased through competition for highly qualified individuals to occupy leadership posts in the staffs of the Regional Medical Programs. The Council believes that a general salary escalation for Program staff would do harm to the achievement of effective cooperation with the medical institutions and medical personnel within the region and might stimulate competition between regions instead of interregional cooperation. The Council would stress, therefore, that applicants and grantees are required to give careful consideration to the salary structure for personnel engaged in the Regional Medical Program to insure a salary scale consistent with that established for similar professional or administrative responsibilities in the applicant institution. If the applicant institution or organization has not previously carried these types of responsibilities the salary scale should bear reasonable and specific comparability to prevailing rates in medical centers or other appropriate institutions in the proposed region.

The Council will expect the applications to contain specific justification for salary rates proposed, and the application should define as precisely as possible the relationships in terms of the responsibilities of the program coordinator and other key officials to the established major medical professional or administrative officers in the region. No unusual or extraordinary salary level should be established for personnel engaged in the Regional Medical Program activities solely by reason of the institution's participation in the program unless specific justification has been supplied and approval received from the Division of Regional Medical Programs at the time of the award of the grant or subsequently.

The Council has asked the staff of the Division of Regional Medical Programs to pay very careful attention to proposed salaries and the justification for these salaries during staff review of applications, negotiations with grantees, and during regular review of the grantees' progress in implementing the program. ...NID 5-15-67

Allowable Direct Costs—

A. Personnel Costs—Salaries and wages of personnel in proportion to the time or effort expended on activities of the Regional Medical Program may be charged to the grant. These costs must be in accordance with applicable institutional policies, and adequate time and effort records must be maintained in order to substantiate these costs. Salaries of personnel whose full time is devoted to the Regional Medical Program should not exceed the salaries of full-time administrative personnel in positions of comparable responsibility in major medical institutions in the Region. Specifically, if a new corporation is organized to serve as the grantee, it must establish salary policies which apply to its personnel under the above policies and which do not exceed equivalent salaries in the major medical institutions in the Region.

Any question concerning the appropriateness of particular salaries or exceptions to these policies should be discussed with the Division Staff.

B. Consultant Services—Regional Medical Program grant funds may be used to pay consultant fees and supporting costs such as travel, and per diem in payment for services related to any Program element of a Regional Medical Program, providing that these services are the most effective means of accomplishing a particular purpose.

- If consultation is obtained from a salaried staff member of the grantee or an affiliated institution, that institution may be reimbursed for a proportionate amount of his regular salary from grant funds. Program records must indicate the total cost and include a statement of activities.

(MORE)

...CHAPTER III, REVISED GUIDELINES, PGs 14-15,

IV. Allowable Direct Costs for Education and Training Activities

The following statements amplify those made in Chapter III, Section VII-C of the revised Guidelines:

A. Categories of Training:

(1) Training Conferences and Seminars: Presentations which are planned for full-time participation for periods from one full day to five consecutive days, or intermittently on a regular basis.
(2) Short-Term Training: Activities which are planned for full-time participation for more than five consecutive days, but not more than a single academic session (quarter or semester).
(3) Long-Term Training: Activities requiring full-time participation for more than a single academic session (quarter or semester).

B. Levels of Training:

Determination of the level of stipend is to be based upon the general level of training to be presented. In the case of training designed specifically for teams of physicians and ancillary personnel, an appropriate stipend level for each general level of participant may be selected, based on educational level attained, experience and current salary level.

(1) Post-High School/Nonacademic: Training which requires completion of a secondary education or having an appropriate equivalent background and experience.
(2) Baccalaureate: Training requiring at least some relevant collegiate preparation, but not more than the baccalaureate degree.
(3) Graduate: Training which requires at least some relevant post-baccalaureate academic preparation but not more than a doctoral degree. Training creditable toward the degrees of M.D., D.D.S., D.O., D.V.M., or similar medical degrees is excluded from support.
(4) Postdoctoral: Training programs designed for holders of a doctoral degree, or who have had equivalent training.

C. Stipends:

Stipends are not authorized for training conferences and seminars, but stipends may be paid for short-term and long-term training programs in accordance with the following general policies:

If the trainee is employed by an affiliated institution, a stipend may be paid directly. A maintenance of income principle can be used to determine the amount of stipend. If desired, the trainee's employer can be reimbursed for the amount of the trainee's salary, including the personnel share of benefits paid by the employer at the time the trainee enrolls in the training being conducted.

NOTE: Amended language in NID 9-13-70

(Contd from Pg 8, Addendum to Revised Guidelines, 2/70, Pg 9)

Payments of stipends (followships, scholarships, etc.) should not exceed the amounts presented in the appended schedule. In no case should such payments exceed the amount set by the policy of the training institution for similar training or training requiring similar pre-requisite education.

Stipends for short-term training are based on a daily rate and are to be paid only for actual training days (weekends, holiday, etc., excluded)

Stipends for long-term training which is less than a full twelve months are to be calculated on a pro-rata basis, and leave and holiday policies of the training institution are to be followed.

Stipend rates for full-time, long-term postdoctoral training are to be paid according to the current policy of the training institution. The Division of Regional Medical Programs will not undertake reimbursement at private practice levels.

D. Dependency Allowances:

Dependency allowances for those long-term trainees at the Baccalaureate level and higher, who are in training for a full academic year, may be awarded in the amount of $500 (per year) for a dependent spouse, each dependent child, and each dependent relative, provided that during the trainee appointment the dependent receives more than one-half of total support from the trainee. A dependency allowance may not be claimed for any person who during the trainee's appointment period will be receiving a fellowship or traineeship stipend under Federal educational assistance program (other than loans), or for whom an allowance will be made as a dependent of any other person during that period.

The Division of Regional Medical Programs has adopted the following dependency schedule and a dependent may now be defined as any of the following individuals over half of whose support, during the period of appointment, is received from the trainee or student:

(1) A spouse,
(2) A son or daughter of the student, or a descendant of either,
(3) A stepson or stepdaughter of the student,
(4) A brother, sister, a stepbrother, or stepsister of the student,
(5) The father or mother of the student, or an ancestor of either,
(6) A stepfather or stepmother of the student,
(7) A son or daughter of a brother or sister of the student,
(8) A brother or sister of the father or mother of the student,
(9) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the student,
(10) An individual who, for the school year has as his principal place of abode the home of the student and is a member of the student's household, or

(Contd from Pg 9, Addendum to Revised Guidelines, 2/70, Pg 10)

(11) An individual who -
  (a) is a descendant of a brother or sister of the father or mother of the student,
  (b) for the school year of the student receives institutional care required by reason of a physical or mental disability, and
  (c) before receiving such institutional care, was a member of the same household as the student.

E. Travel Allowance:

The cost of the trainee's travel to the training institution may be allowed only for the purpose of, and at the time of, entering and leaving the training program. The allowance is payable only once to any one trainee from any one training project. If private transportation is used, a travel allowance of 8 cents per mile, as computed by standard mileage charts, may be paid from grant funds for travel to the training institution from the trainee's last place of residence and return. Payment of travel allowance is limited to participants who must travel more than 50 miles round trip between their residence and the training site. In general, travel policies of the training institution will apply, or in the event no such policies exist, Government Travel Regulations will apply. No allowance can be made for transportation of dependents, or for shipment of household goods or personal effects.

F. Per Diem Allowance:

An allowance of $16 per day may be paid to participants in training conferences and seminars, and in short-term training programs (see schedule) who must travel more than 50 miles round trip between their place of residence and the training site.

G. Supplementation:

As used in all Public Health Service policy statements and procedural guides dealing with training stipends, the term "supplementation" means the provision of funds by a grantee to a trainee in addition to his grant-supported stipend, in a combination which then exceeds established Public Health Service stipend ceilings. Trainees in full-time, long-and short-term programs funded by the Division of Regional Medical Programs are required to devote their entire professional effort in the pursuit of the training objectives.

The source of funds for supplementation must be non-Federal.

(Contd from Pg 10, Addendum to Revised Guidelines, 2/70, Pg 11)

H. Schedule of Stipends:

Grant funds used for the payment of stipends and related benefits to eligible persons undertaking an education or training activity approved as part of a Regional Medical Program grant may not exceed the following schedule:

	Stipend Per Year	Stipend Per Day	Dependency Allowance	Per Diem	Travel
I. Training Conferences & Seminars	None	None	None	Yes	Yes
II. Short-term Training					
1. Post high school	-	$10	None	Yes	Yes
2. Baccalaureate	-	$20	None	Yes	Yes
3. Graduate	-	$30	None	Yes	Yes
4. Post doctoral	-	$50	None	Yes[1]	Yes
III. Long-term Training[2]					
1. Post high school	$1500	-	Yes	No	Yes
2. Baccalaureate	$2400	-	Yes	No	Yes
3. Graduate					
a. (first post-baccalaureate year)	$2400	-	Yes	No	Yes
b. (years between first and terminal year)	$2600	-	Yes	No	Yes
c. (terminal year)	$2800	-	Yes	No	Yes
4. Post doctoral					
a. Board creditable	[3]	-	Yes	No	Yes
b. Special	[3]	-	Yes	No	Yes

[1] Per Diem can be paid in lieu of (not in addition to) a stipend.

[2] The following DHEW stipend policy is applicable: "The purpose of the the student support is to provide for a level sufficient to enable the student to continue his studies without delaying the attainment of the degree or causing him to seek outside sources of financial aid."

[3] Stipend may be negotiated on the basis of trainee's education, experience, and current salary level, and then must be approved by the Division of Regional Medical Programs.

Director
Regional Medical Programs Service

September 2, 1969

THRU : Associate Director for Operations & Development, DRMP
Chief, Grants Management Branch
Division of Regional Medical Programs

DRMP Policy Regarding Payment of Meals from Grant Funds

Division staff and many RMP personnel have desired a clear policy statement with respect to the payment of meals from grant funds. In the absence of written policy to questions such as, "Can the RMP charge meals to the grant that are consumed by RAG members when the meeting begins at 3:00 p.m. and ends at 9:30 p.m.?" I have responded in this fashion:

> Bureau of the Budget Circular A-21 permits the payment for meals and the charging of such costs as a direct cost to the grant account, providing the meals are incidental to a conference or meeting, where the primary purpose is the dissemination of [illegible] technical information regarding the RMP grant activities. From this rather broad statement, one can list a series of elements which must be met to permit the charging of meal costs, which are (1) the meals must not be incurred in connection with entertainment, (2) the costs of meals must be reasonable, (3) no alcoholic beverages may be charged to the grant account, (4) the direct cost expense of charging meals must be allowable within the grantee or affiliated institution's policy, (5) charges for meals may be incurred only during those hours when meals normally are consumed.

The above paragraph has been my response to questions for meal payment that would involve RAG and small groups of committee members.

In addition, a recent example of uncertainty in this area was posed by the Western Pennsylvania RMP. The Region intends to have 350 members of the Area Committees attend a dinner at a cost of $6.25 per person. In this era of fiscal tightness it seems unreasonable to pay $2,187 for a banquet type meeting. But, on the other hand, if a group of 30 local RAG or committee members work through dinner and eat a club sandwich plus a glass of milk should DRMP preclude payment from grant funds? It appears that a middle-of-the-road approach is desirable which would permit the payment of meals either up to a dollar ceiling or for stipulated "types" of meetings.

Consider inflation ?

Until a policy is developed, I plan to continue advising regions as in the past, subject to any modifications that you would desire.

Gregory W. Lewis

Dr. Manegold
Mrs. Phillips
Mr. Jones
Mrs. Silsbee

REPLACE Chapter III, Section VII. Financial Management, Allowable Direct Costs, B. Consultant Services (page 14) with:

B. Consultant Services - Regional Medical Program grant funds may be used to pay consultant fees and supporting costs such as travel and per diem in payment for services related to any program element of a Regional Medical Program. Consultants may be selected from both within and outside the grantee or affiliated organization, providing that these services are the most effective means of accomplishing a particular purpose.

It is expected that grantee organizations will normally have their own policies with respect to use of consultant services, that those policies will apply equally to the use of consultants paid for by grant funds and that they will include, as a minimum, the standards for documentation described below. However, in the absence of such policies, the following documentation in support of the use of consultants must be provided:

- A statement of the services to be performed and evidence that they cannot be provided by payment of direct salaries to staff members of the grantee or an affiliated institution;

- A brief description of the process of selection of the individuals most qualified to provide the required services;

- Evidence that the fee is appropriate considering the qualifications of the individuals, the nature of the services performed, and the amount normally paid for such services from sources other than Regional Medical Programs.

As a general rule, when services of a salaried staff member of the grantee or an affiliated institution are to be provided fulltime for periods of two weeks or more, or on a regularly occurring basis throughout the year, the individual should be compensated on a part-time salary basis rather than as consultation.

Grant funds may not be used to pay fees and supporting costs to U.S. Government employees regardless of their employment or pay status.

...Addendum to Revised Guidelines, 2/70, Pg 3

NOTE: See NID 10-13-70.

NOTE: Reference to Program Management (Personnel Practices)

Direct Costs Not Allowed—The following direct costs or charges are not allowable:

(1) Honoraria as distinguished from consultant fees

(2) Entertainment (cost of amusement, social activities, entertainment and incidental costs thereto, such as meals, lodging, rentals, transportation and gratuities)

(3) Payment to Federal employees

(4) Petty cash funds

(5) Subgranting (a subgrant is any allocation of grant funds by the grantee to other individuals or organizations for purposes over which the grantee institution named on the application does not maintain scientific and financial responsibility. A grantee may contract for services, but may not subgrant).

...CHAPTER III, REVISED GUIDELINES, Pg 16

A. Issues Identified

1. In the matter of RMP support of short-term training projects, the Council considered the history provided them by staff, and a number of specific projects included in the applications under review at this meeting. They believe that under most circumstances it is not necessary or appropriate for Regional Medical Programs grant funds to be used to cover the full costs of both the presentation of short-term training projects and of stipends and expenses of the participants.

The majority of projects in this category provide opportunities for upgrading and development of new skills in special techniques or procedures and are directed to individuals presently employed in health care institutions. Under the circumstances these institutions should, and in most cases do, make regular provision for this kind of training for their staffs.

The Council therefore recommended the following changes in policy guidelines regarding payments to participants in continuing education and training projects (as defined in the Guidelines Addendum, February 1970, page 13) which are supported by Regional Medical Program grant funds.

- Regional Medical Program grant funds may not be used for the payment of stipends, either directly or on the "maintenance of income principle," to participants in short-term continuing education and training projects. This does not include training for new careers for new types of health personnel.

- Other allowable costs of participant's support may be calculated according to the existing Guidelines. Regional Medical Program grant funds may be requested and awarded for per diem and travel to the extent of 50% of the total amount so derived. The awarded funds may then be paid to the enrolled trainees as considered appropriate by the project personnel, depending on the participants' ability to provide these costs for themselves and/or the willingness of their employers to provide them. No single individual may receive per diem or travel allowance at a rate higher than that prescribed by the present Guidelines.

- RMP funds may not be rebudgeted, from within or without the project budget, to increase the total amount awarded for per diem and travel above the 50% level. ...July 28-29, 1970 Council Minutes

NOTE: See wording of exerpts printed in NID 10-13-70.
Cross-reference to Eligible Activities (Manpower and Training)

A communication device designed to speed the exchange of news, information and data on [R]egional Medical Programs and related activities.

EXPANSION OF Policy Change Re Education and Training Activities and Consultant Services

December 15, 1970 - Vol. 4, No. 55S

Regional Medical Programs Service herein clarifies a change in policy which was announced and may have been misinterpreted in the October 13, 1970 Special Issue - News, Information and Data - Vol. 4, No. 43S.

"Payment of stipends and other participant costs . . .

These changes amend the Expanded Statement of Education and Training Guidelines for Regional Medical Programs issued in August 1968 and published in Addendum-Guidelines, February 1970, on pages 5-12, and relate specifically to items C, D, E, F, and H of Section IV. The changes will be effective in awards made on the basis of all new, continuation, and renewal applications submitted on or after February 1, 1971.

. . .

In connection with long-term training projects . . ."

- Payment of stipends and other participant costs for long-term post-doctoral support at the senior resident and post-resident levels, particularly in the clinical sub-specialties of importance in patient management in the diseases targeted by Regional Medical Programs Service, may not be made from operational grant funds awarded under Section 904 of Title IX of the Public Health Service Act.

NOTE: Cross reference to Eligible Activities, Continuing Education, Training & Manpower

[illegible]

The following excerpts from the minutes of the July 28-29, 1970 meeting of the National Advisory Council provide background for the new policy regarding the use of grant funds for trainee stipends:

"In the matter of RMP support of short-term training projects, the Council considered the history provided them by staff, and a number of specific projects. They believe that under most circumstances it is not necessary or appropriate for Regional Medical Programs grant funds to be used to cover the full costs of both the presentation of short-term training projects and the costs of stipends and expenses of the participants.

The majority of projects in this category provide opportunities for upgrading and development of new skills in special techniques or procedures, and are directed to individuals presently employed in health care institutions. Under the circumstances these institutions should, and in most cases do, make regular provision for this kind of training for their staffs.

The Council considered the present Guidelines regarding Regional Medical Program funding of projects of long-term post-doctoral training, at the senior resident and post-resident levels, particularly in the clinical sub-specialties of importance in patient management in the diseases targeted by Regional Medical Programs. As has been pointed out by both the Review Committee and the Council, requests for support for training of this kind are appearing more and more frequently in Regional Medical Programs applications; because of the increasingly critical shortage of individuals trained in these fields, but also because of the drastic reduction in NIH funding which has previously been available for this purpose.

The Council unanimously agrees on the importance of maintaining the training programs in these fields in the major teaching centers throughout the nation. They also agree that funding through Regional Medical Programs would serve to strengthen the essential involvement of these centers of clinical excellence into the framework of cooperative arrangements which form the basis of the Region of which they are a part. It is recognized, however, that the allocation of an amount of funds large enough to make a significant impact, if provided from the present RMP appropriation, would create a serious and inappropriate imbalance in the RMP effort to meet their more varied and

(MORE)

...NID 10-13-70

NOTE: Reference to Eligible Activities (Training).

Payment of stipends and other participant costs . . .

These changes amend the Expanded Statement of Education and Training Guidelines for Regional Medical Programs issued in August 1968 and published in Addendum-Guidelines, February 1970, on pages 5-12, and relate specifically to items C, D, E, F, and H of Section IV. The changes will be effective in awards made on the basis of all new, continuation, and renewal applications submitted on or after February 1, 1971.

In connection with short-term training projects . . .

- Grant funds may not be used for the payment of stipends, either directly or on the "maintenance of income principle," to participants in short-term continuing education and training projects. Training for new careers for new types of health personnel is not included.
- Other allowable costs of support of participants may be calculated according to the existing Guidelines. Grant funds may be requested and awarded for 50 per cent of the total amount budgeted for per diem and travel of the trainees. The awarded funds may then be paid to the enrolled trainees as considered appropriate by the project personnel, depending on the participants' ability to provide these costs for themselves, and/or the willingness of their employers to provide them. No single individual may receive per diem or travel allowance at a rate higher than that prescribed by the present Guidelines.
- Grant funds may not be rebudgeted, from within or without the project budget, to increase the total amount awarded for per diem and travel above the 50 per cent level.

In connection with long-term training projects . . .

- Payment of stipends and dependency allowances to participants in long-term, post-doctoral training may not be made from operational grant funds awarded under Section 904 of Title IX of the Public Health Service Act.
- However, grant funds for the planning or conduct of such training and educational projects may be used for the payment of trainee travel as provided in the present Guidelines.

...NID 10-13-70

7
6

NOTE: Reference to Eligible Activities (Training)

I. Tuition and Fees:

Tuition and fees for training activities may be paid from grant funds providing no other charges for the cost of that training are made against the grant. When allowable, only the same resident or non-resident tuition and fees charged to regularly enrolled non-Federally supported students may be charged for trainees. Tuition and fees for courses which satisfy requirements related exclusively to the M.D., D.D.S., D.O., D.V.M., or similar degrees may not be charged to a grant. When the courses are creditable to satisfying Ph.D. requirements in combination with any of the aforementioned degree requirements, however, tuition and fees may be charged for those courses within the combined degree program that are required specifically for the attainment of the Ph.D. degree. The training must be relevant to the purposes of the grant. 12

...Addendum to Revised Guidelines, 2/70, Pg 12

*The Council has recommended a policy which precludes the use of RMP funds for basic training in certain established allied health fields, including nuclear medicine technology (see Section X A2 of Minutes).

Council 8/69

...August 26-27, 1969 Council Minutes

Reimbursement for travel and other related costs for Federal employees serving as consultants to Regional Medical Programs . . .

This change further amends the Guidelines regarding the use of grant funds for direct costs of consultant services as it currently appears in the Addendum-Guidelines issued in February 1970, page 3, so that . . .

- Grant funds may be used to pay the supporting costs but not consultant fees of U.S. Government employees who represent cooperating agencies and institutions within the Region for their participation in the planning or conduct of Regional Medical Program activities.

- This change is made to promote the cooperation and participation of local Federal Government agencies in Regional Medical Programs in instances where an individual agency cannot provide for this expense.

...NID 10-13-70

NOTE: Reference to Program Management.

(Following is a statement dtd 6-25-70 from GMB regarding reimbursement of costs incurred by Federal employees participating in training activities:

1. A stipend cannot be paid to a Federal employee unless he is on leave-without-pay status from his employing agency.

2. Per diem may be paid to a Federal employee providing he elects not to receive a stipend and the employing agency does not provide concurrent per diem.

3. Travel costs may be paid a Federal employee providing the employing agency does not provide concurrent travel costs.

(Direct Costs Not Allowed)

Consultant Services: Ltr, dated 10-20-70, from Program Coordinator, Tennessee Mid-South RMP, requesting permission to use grant funds to reimburse members of their RAG at $100 per day of attendance at regular RAG meetings. Ltr, dated 11-12-70, signed by the Acting Director, Harold Margulies, M.D., to Dr. Paul E. Teschan in response states:

"...we have advised the various RMPs that the payment of consultant fees or other remuneration to RAG members should be avoided. It is felt that such service should be freely offered in the spirit of a voluntary contribution to the community and region which are being served. It is entirely appropriate, for example, to reimburse members for travel expenses either on a per diem, actual and necessary, or a mileage basis when such costs are incurred. I would be remiss if I failed to point out that on occasion there have been exceptions to the above stated policy, when consultant's funds were earmarked for salary reimbursement to nonprofessional members of the RAG who sustained a loss of salary due to the absence from their place of employment. We do not feel, however, that this exception should be extended to professional personnel...".

NORTH DAKOTA REGIONAL MEDICAL PROGRAM

8/69.1 - Initial operational and renewal of core - Approval in the time and amounts and with the conditions recommended by the site visitors and the Review Committee; and with the added contingency that no funds budgeted for "in-State Consultants" be paid to members of the Planning Committee and other Committees for their services as members of those groups.

...August 26-27, 1969 Council Minutes

October 16, 1970

RM-00046

Mr. G. W. Adams, Jr.
Fiscal Officer
Georgia Regional Medical Program
938 Peachtree Street
Atlanta, Georgia 30309

Dear Mr. Adams:

Regional Medical Programs Service policy provides that funds awarded from a Regional Medical Program grant may not be used for supplementation of stipends and allowances. Therefore, Emory University is at liberty to reimburse Dr. Parsons for her expenses providing that the funds are not derived from either a grant awarded by the Regional Medical Programs Service or the National Institutes of Health.

Sincerely yours,

Lawrence H. Pullen
Grants Management Officer
Grants Management Branch

GMB:LHPullen:kef
RMP Grant File
DPTD File
Mr. Gilmer
Mrs. Silsbee
Mr. Pullen
Board/File

Indirect Costs—Indirect costs related to the conduct of the Regional Medical Program are reimburseable. To be eligible for reimbursement, an indirect cost proposal must be developed by the performing institution in conformity with its established accounting system and submitted to the Division of Regional Medical Programs. The proposal must identify those administrative services provided to the program during the institution's fiscal year, the costs of the services and the basis or methods for apportioning those costs to the Regional Medical Program and other activities of the institution. A new proposal must be submitted at the end of each fiscal year.

The Department of Health, Education, and Welfare has published separate guides for establishing indirect cost rates applicable to educational institutions, hospitals, State and local government agencies, and other non-profit institutions which provide guidelines and criteria for the identification of indirect costs reimburseable under research grants and contract, and for apportionment of administrative costs to the major operating activities of the institution. The booklets contain cost principles which define direct and indirect costs and provide information on the allowability of specific items of cost. They describe methods of cost apportionments and allocations, instructions on the development of indirect cost rates and sample indirect cost proposals. Although oriented primarily toward the research activity, the policies and criteria contained therein are relevant to the Regional Medical Program and should be used as a guide.

Institutions performing under Regional Medical Program grants may also be the recipient of grants or contracts under other Federal programs. It is essential that consistent procedures for determining reimburseable costs for similar services be employed without regard to program differences. Additional information and assistance may be obtained from the Division of Regional Medical Programs, National Institutes of Health, Bethesda, Maryland 20014. The Department of Health, Education, and Welfare cost guides may be obtained from the Government Printing Office, North Capital between G & H Streets, N.W., Washington, D.C. 20402.

...CHAPTER III, REVISED GUIDELINES, Pg 16

Chief, Cost Policy and Rate Negotiation Branch
Division of Grants Administration Policy, DHEW

November 13, 1969

Chief, Grants Management Branch
Division of Regional Medical Programs

Indirect Costs - Grantee Overhead Service Charges

Reference is made to my memorandum of April 25, 1969 in regard to this subject.

My previous memorandum requested a ruling on the legality and appropriateness of awarding indirect costs as compensation for grantee accounting and administrative services provided affiliated institutions. Exemplary attachments from Iowa, Missouri, Bi-State, and Tennessee Mid-South Regional Medical Programs were provided for your reference. To date, a ruling has been provided for the Iowa, Missouri, and Bi-State requests, but guidance has not been received concerning the Tennessee Mid-South RMP. Although all the other requests were denied, the impression has been received that denial was due to inadequate justification and not the inappropriateness of this type service charge.

Whereas "service charge" indirect cost has not been awarded to any other Grantee, it is noted that Vanderbilt University (Grantee for the Tennessee Mid-South RMP) has been provisionally awarded this "service charge" indirect cost. The amount has been computed at the established off-campus rate for activities conducted at affiliated institutions.

The Grants Management Branch, DRMP, is currently accelerating its effort to process Reports of Expenditures from prior years operations. Accordingly, guidance is urgently needed in regard to allowing or disallowing this type charge when processing the Tennessee Mid-South RMP expenditure reports. Your prompt response is respectively requested.

Since the precedent has been established for provisionally providing this "service charge" to the Tennessee Mid-South RMP, this procedure will be continued in future awards, as in the current award, until advised otherwise.

Gregory W. Lewis

GWLewis:GHinkle/nb
cc: DRMP Grant File

SUPPLEMENT Chapter III, Section VII. Indirect Costs (page 16) with:

I. Negotiation of Indirect Cost Rates for Grantee Institutions

A. The Division of Grants Administration Policy (DGAP) - Department of Health, Education, and Welfare will establish rates for each grantee institution which requests indirect cost.

B. These rates will be based on proposals submitted by the grantee institution as follows:

1. If the grantee is the recipient of awards under other DHEW programs which reimburse indirect cost, it will submit a single annual submission to DGAP proposing rates for all DHEW programs. A RMP rate will be established at the time the rate(s) for the other programs are negotiated. In most instances the RMP rate will be identical to the rate used for research and development awards.

2. If the grantee is not the recipient of awards under other DHEW programs, it must submit a rate proposal for the RMP award together with supporting financial statements. This proposal will be requested by and submitted to the Grants Management Branch - Division of Regional Medical Programs which will review it for completeness and, if adequate, forward it to DGAP for processing.

C. When a rate has been established by DGAP, it will be incorporated in a rate agreement and identified as being applicable to the RMP grants.

D. The DRMP had established a number of rates for provisional use before the rate setting function was assumed by the DGAP. These rates will continue to be utilized until revised by DGAP in the normal course of business.

E. The DRMP will advise the DGAP immediately of any grantee institution under category I.A. for which rates are required but not now available.

The DRMP will immediately procure proposals from those institutions under category I.B. for which rates are required but not now available.

F. If DRMP makes an award to a new grantee which has an established research rate with DGAP, it may, with the concurrence of the grantee institution, utilize the research rate as a provisional rate in the initial award in order to fund the grant.

(Contd from Page 21, Addendum to Revised Guidelines, 2/70, Pg 22)

II. Negotiation of Indirect Costs for Affiliate Institutions

A. It will be the responsibility of the grantee institution to establish indirect cost rates with its affiliated institutions. Affiliated institutions generally will not communicate directly with the Division of Grants Administration Policy-DHEW regarding the establishment of indirect cost rates for Regional Medical Program grants. The Division of Grants Administration Policy will provide technical advice to the grantee institution upon request.

B. Some grantee institutions do not now possess the resources to establish indirect cost rates with their affiliates. Such grantee institutions are expected to develop the necessary resources. We appreciate that these resources cannot be developed immediately and are amenable to an interim, short term arrangement whereby DGAP will, upon request, and the condition that all parties are agreeable, establish rates with the affiliate(s) on behalf of the grantee. DRMP will advise DGAP of such instances and the grantee will instruct the affiliate institution to forward its proposal and supporting financial statements to the Grants Management Branch - Division of Regional Medical Programs. DRMP will review the proposal for completeness and, if adequate, forward it to DGAP. DGAP will conduct its negotiation directly with the affiliate(s).

C. Some institutions participating in the Regional Medical Program as affiliates are the direct recipients of grants or contracts under other DHEW programs. In such situations DGAP will establish rates for the RMP grant when it establishes rates for the other program awards. It is understood that this is an arrangement of administrative convenience for all parties involved. If the grantee institution desires to conduct direct negotiations with its affiliate, it may do so DGAP will be advised, however, of the grantee's option, in order that the RMP award may be considered in DGAP's negotiation for the other programs performed by the grantee institution.

The Division of Grants Administration Policy-DHEW has developed cost principles applicable to educational institutions, hospitals, state and local government agencies and other non-profit institutions. The following brochures are enclosed to assist you in developing the required indirect cost rate proposals:

OASC - 1 A Guide for Educational Institutions
OASC - 3 A Guide for Hospitals
OASC - 4 A Guide for State and Local Government Agencies
OASC - 5 A Guide for Non-profit Institutions

Rebudgeting of Funds—The grantee or affiliated institutions with full knowledge and approval of the grantee may depart from the approved budget and use the funds for other items required for the project, except for the following restrictions:

(1) Grant funds may not be used for any purpose contrary to the regulations and policies of the Division of Regional Medical Programs or the grantee or the affiliated institutions.

(2) Grant funds may be transferred between budget categories within projects or activities only to the extent that no substantial change in any such project is made by the transfer (see changes in approved program, page 12). Budget changes between projects or other identified activities however, require written approval of the Division of Regional Medical Programs. Rebudgeting should not be done within the period between submission of a continuation application and receipt of the award, and required special justification and written approval from the Division of Regional Medical Programs under exceptional circumstances.

...CHAPTER III, REVISED GUIDELINES, Pg 17

APPLICATION FOR PROGRAM REVISION (REBUDGETING OF FUNDS)

Under the authority of the Regional Medical Programs legislation, a single grant, based officially upon a single budget, is made to each Regional Medical Program. Although this transaction is based upon the financial requirements of a great many program components, each justified and approved separately, its purpose is the support of a total Regional effort. In attaining operational status each Region accepts the obligation to evaluate the progress of each of the components and assess the total program they comprise. It also has the option of periodically reassigning its available resources in accordance with emerging plans and priorities. At this crucial time when the amounts of new funding are uncertain and at least temporarily limited, it is important for the Program to understand fully the process of rebudgeting--both the opportunities it provides and its limitations.

Based upon its own assessment a Regional Medical Program may propose reallocation of its grant resources among (1) the direction, planning, and professional service activities of its central staff; (2) funded operational projects; and (3) projects or staff activities which have been approved by the National Advisory Council. Such reallocation requires prior approval of the Division of Regional Medical Programs and is usually applied for as part of the Type V (non-competing continuation) application. Transfer of funds between budget categories within component budgets may continue to be made without prior approval but only to the extent that it makes no substantial change in the approved activity.

A Region may propose rebudgeting of funds committed for the continuation year and carryover of funds unexpended in the year ending. In applying for program revision a Region must fully understand the provisions under which approval of its plans may be granted.

- The program components involved in the reallocation--those from which, as well as those into which, the funds are to be transferred--may not be substantially altered in their purposes, goals, or methodologies. A decision to discontinue a project, short of the time for which it was initially approved and for which funds were committed, must be explained.

- Rebudgeting of funds among projects may not serve to increase the general level of funding of the entire program in the current or future years, (e.g. the size of a project staff may not be increased so that the annualized payroll is in excess of the approved budget).

...NID 1-2-70

Major Investments in Medical Equipment

"The Council agreed that, in order to be considered for final recommendation by it, all applications which include requests for purchase of major items of fixed and moveable therapeutic and diagnostic equipment must include....

- A statement of the rationale for charging any or all of purchase price of the equipment to the grant, and of the justification for the proportioning of the shared costs among those involved in the purchase;

- A proposed plan for accounting and fiscal control of the revenues accruing to the project (see HEW Grants Administration Manual Issuance, Disposition of Grant-Related Income);

- Adequate evidence that the project plan, including the acquiring of the equipment, has been reviewed, and if necessary, approved by the appropriate local planning agencies."

-- February 20-21, 1969 Council Meeting

After re-studying the project, the Council further recommended that the RMP contribution to the acquisition of fixed equipment be limited to not more than half of the total equipment budget of the facility; the portion being roughly equivalent to the amount of use of the equipment for teaching and demonstration. ... August 26-27, 1969 Council Meeting

**Although the Council persists in its unwillingness to further specify its present policy guidelines on expenditure of grant funds for equipment, there was general agreement that each of these two projects has as its primary objective the establishment of a service facility for one institution and does not include a satisfactory plan for teaching, patient demonstrations and/or extension of services to a population not now well served. The Council recommended that in the context of these projects the purchase of equipment (and thereby the projects themselves) be disapproved.

...Agust 26-27, 1969 Council Meeting

NOTE: Cross-reference to Program Management - Eligible Activities

F. Alterations and Renovations—To the extent that other sources of Federal and non-Federal funds are not readily available to the applicant for such purposes, ninety percent of the costs of construction, i.e., alteration, remodeling and renovation of existing buildings (including initial equipment thereof) and replacement of obsolete built-in equipment of the types customarily included in a construction contract may be paid for by operational grant funds. The applicant is required to furnish a narrative description to indicate the need, nature and purpose of the proposed alterations and renovations, and, in appropriate instances, detail the plans and specifications. The amount of the alteration and renovation costs requested as part of a Division of Regional Medical Programs grant determines the types of supporting documents to be submitted by the applicant. Applicants are referred to the procedures and regulations set forth in the "Regional Medical Programs—Alterations and Renovations Guide," available on request. CHAPTER III, REVISED GUIDELIN.

ADD. See Chapter III, Section VII. Financial Management, Part F (page 15):

REGIONAL MEDICAL PROGRAMS

ALTERATION AND RENOVATION GUIDE*

(SUPPLEMENT 2)

(MORE)

Page

A&R Guide, dated 7-7-79.

SECTION V - PREPARATION AND SUBMISSION OF GRANT APPLICATIONS

(Excerpted from letter to Members of the National Advisory Council on Regional Medical Programs, dated November 4, 1970, signed by Vernon E. Wilson, M.D., Administrator, HSMHA)

2. The responsibility for review and approval of individual projects under an approved RMP Program grant is delegated to each Regional Medical Program. Appropriate review criteria and procedures must be established by the RMP and approved by both the National Office and the Advisory Council where appropriate.

3. The Advisory Council will be responsible for an in-depth general program review of each RMP on a triennial basis. This will include a site visit in which the HEW regional staff will [illegible]

4. The Regional participation will be as follows:

a. Copies of Program Applications will be sent to the Regional Office from the local RMP for information and comment to be forwarded on to HSMHA RMPS.

b. Copies of Award Statements will be sent to the HEW Regional Office by HSMHA RMPS.

c. Program Assistance activities will be conducted from the HEW Regional Office by approved staff. This pertains to ongoing Program Assistance and does not prohibit central staff involvement in special items which involve the National Council.

d. HEW Regional Office staff will participate in all program review site visits.

e. Agreements will be executed to assign responsibility to a single regional office for those RMP's which cross HEW regional boundaries.

f. Continuing review of Programs (as distinguished from continuation renewal) will be conducted by staff in the Regional Office. The annual review and approval of continuation program grants will be conducted by the National and the HEW Regional Office in concert. Only those grants which have significant problems or involve the significant redirection of activities will be routinely brought to the attention of the National Advisory Council.

REVIEW AND APPROVAL PROCESS

(Exerpted from letter to Members of the National Advisory Council on Regional Medical Programs, dated November 4, 1970, signed by Vernon E. Wilson, M.D., Administrator, HSMHA)

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a. Copies of Program Applications will be sent to the Regional Office from the local RMP for information and comment to be forwarded on to HSMHA RMPS.

b. Copies of Award Statements will be sent to the HEW Regional Office by HSMHA RMPS.

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C. Regional Medical Programs in Model Cities - Mr. Cleveland Chambliss

The Council was reminded of the administrative earmarking of $1.9 million of RMP FY 71 grant funds for use in projects which have direct impact on certain designated Model Cities neighborhoods. Mr. Chambliss outlined the procedure for determining the degree of such impact and obtaining the certification of Model Cities officials in this regard. Although this procedure includes endorsement of DHEW Regional officials, Mr. Chambliss assured the Council that the procedure would entail no authority for further review and approval of these projects beyond the local Regional Advisory Group and the National Advisory Council.

Also in response to specific questions, Dr. Margulies explained that Regional Medical Programs which are planning and submitting projects to serve urban populations need not plan them exclusively for Model Cities areas and need not seek any endorsement or concurrence beyond their own review and approval mechanism.

NOTE: ...July 28-29, 1970 Council Minutes

...communication device designed to speed the exchange of news, information and data on ...ional Medical Programs and related activities.

FACTS AND SCHEDULE-REVIEW CYCLES OF GRANT APPLICATIONS Fiscal Years 1971 and 1972

November 2, 1970 - Vol. 4, No. 50S

This issue updates the schedule of Regional Medical Program application review cycles for the remainder of Fiscal Year 1971 and the first half of Fiscal Year 1972.

It should be noted that . . .

- Beginning July 1, 1970, Regional Medical Programs Service inaugurated an anniversary review system, which provides for four review cycles a year. Under this system, each Program will submit a single annual composite application into one of the review cycles shown on Page 2.

- Because this is a transition year, Programs whose anniversary dates are September 1, October 1, November 1, December 1, 1970, and January 1, 1971, may submit their continuation applications 45 days prior to their anniversary date. These Programs will be permitted to submit separately, one additional application package containing requests for developmental component and/or supplemental and renewal projects in time for the earliest of the deadlines that they can meet.

IV. Application Procedure

A. Schedule

Applications to the Division of Regional Medical Programs may be submitted at any time. A date set approximately six weeks prior to each meeting of the Regional Medical Program Review Committee is set as the limit for receipt of applications for the review cycle initiated by that meeting. There are usually four such cycles each year. A calendar of these dates and the dates of all Review Committee and the National Advisory Council meetings is kept current for at least one full year in advance and distributed regularly to all program coordinators.

B. Number of Copies

Applicants are requested to submit twenty copies of an application.

C. Style

Applicants should adopt a typographic style which will permit stapling or binding in a three-ring binder. Each page should be suitable for photographic reproduction. The narrative should be typed single spaced to conserve space.

SUPPLEMENT Chapter IV, Section IV. Application Procedure (page 21) with:

"As non-competing continuation applications (previously recommended support-type V) become more complex, an increasing amount of time is required for the staff of the Division of Regional Medical Programs to adequately review them. This fact, coupled with the need that Award Statements for such continuing support arrive prior to the scheduled starting date of the new grant period, now makes the following policy necessary and effective immediately:

> Programs scheduled to start their next budget period on August 1, 1969 or thereafter, must submit their continuation applications to the Division at least 45 days in advance of that new starting date, rather than the 30 days presently required.

Similarly, the Division will advance its schedule for contacting Regions regarding the submission of their Type V applications."

APPLICATION FOR PROGRAM REVISION (REBUDGETING OF FUNDS)

Under the authority of the Regional Medical Programs legislation, a single grant, based officially upon a single budget, is made to each Regional Medical Program. Although this transaction is based upon the financial requirements of a great many program components, each justified and approved separately, its purpose is the support of a total Regional effort. In attaining operational status each Region accepts the obligation to evaluate the progress of each of the components and assess the total program they comprise. It also has the option of periodically reassigning its available resources in accordance with emerging plans and priorities. At this crucial time when the amounts of new funding are uncertain and at least temporarily limited, it is important for the Program to understand fully the process of rebudgeting--both the opportunities it provides and its limitations.

Based upon its own assessment a Regional Medical Program may propose reallocation of its grant resources among (1) the direction, planning, and professional service activities of its central staff; (2) funded operational projects; and (3) projects or staff activities which have been approved by the National Advisory Council. Such reallocation requires prior approval of the Division of Regional Medical Programs and is usually applied for as part of the Type V (non-competing continuation) application. Transfer of funds between budget categories within component budgets may continue to be made without prior approval but only to the extent that it makes no substantial change in the approved activity.

A Region may propose rebudgeting of funds committed for the continuation year and carryover of funds unexpended in the year ending. In applying for program revision a Region must fully understand the provisions under which approval of its plans may be granted.

> The program components involved in the reallocation--those from which, as well as those into which, the funds are to be transferred--may not be substantially altered in their purposes, goals, or methodologies. A decision to discontinue a project, short of the time for which it was initially approved and for which funds were committed, must be explained.
>
> Rebudgeting of funds among projects may not serve to increase the general level of funding of the entire program in the

(Contd)

(Contd from Pg 1, Addendum to Revised Guidelines, 2/70, pg 2)

current or future years (e.g., the size of a project staff may not be increased so that the annualized payroll is in excess of the approved budget).

Funds carried forward from a previous budget period may be used for initiation or expansion of projects or staff activities which can be completed within one year. The temporary increase in the level of funding created by the approval of carryover funds does not constitute a commitment to increase the level of funds for subsequent years. NOTE: Funds remaining unexpended at the end of a period of committed support (i.e., the one, two, or three year program period) generally cannot be carried forward. Due to the complexities of individual situations, however, Regions planning to request carryover as part of Type II - competing renewal applications are advised to contact the Grants Management Branch.

APPLICATION

Application for program revision should, as often as possible, be made as part of the regular Type V (non-competing continuation) application, whether the proposed revision is to be accomplished by rebudgeting or by use of carryover funds. Application for revision submitted at any other time will be considered under special circumstances and after direct discussion with the Division staff. Each such application must be made utilizing the regular face page and budget pages (NIH-925-1 Rev. 5/66); with a budget for each of the projects affected by the revision and a consolidated budget for the entire program.

Under no circumstances will such requests be considered following the effective date of the final Report of Expenditures (NIH-925-3) which is due 120 days after the end of each budget period.

If a project selected for initiation with rebudgeted funds was originally applied for and approved for more than one year, the application must include not only a budget for that project but a statement explaining how it has been revised to be accomplished within that budget and within the one year for which the request can be considered. Such applications should include a statement concerning proposed sources of support for proposed continuation of the activities.

REVIEW

When adequately presented as part of a Type V application, the Division staff can review and act on such requests for revision in the usual time required for the Type V alone. However, if the staff concludes that the proposed reallocation will result in alterations either in individual grant components or in the nature of the applicant's total program, staff may defer action on the revision request and submit it to the National Advisory Council at its next regular meeting. This can be done without delaying processing of the other elements of the Type V application.

NOTE: See Financial Management - Rebudgeting of Funds - Page ___

GLOSSARY

Delegation of Authority by National Advisory Council on Regional Medical Programs to the Division of Regional Medical Programs Staff for Administrative Changes in Amounts of On-Going Grants

On August 28, 1967, the Council approved the following delegations of authority to the Division staff to approve increases in amounts for active grants for the following purposes:

(1) Institution-wide salary increases, social security and other mandatory employer contribution adjustments.

(2) Extension of grant period with additional funds, at a rate not to exceed the current rate of support, for a period not to exceed 6 months--in order to prevent hardship to personnel or loss of investment already made under the grant, to provide additional time for preparation, review, and approval of a renewal application, or to provide for orderly termination of the grant. Such extension would be reported to the Council.

(3) Increases of an administrative nature which do not represent an expansion of the program or change in any significant manner the nature of the program, such as increased costs for equipment, personnel, travel, rental, and alterations and renovations. Such increases would be limited to 15 percent for any budget category and all increases would be reported to the Council.

(4) Rebudgeting of allowable indirect costs to direct cost expenditures with an equivalent reduction in the indirect cost allowance (an increase in direct costs only, not in total grant amount).

In requesting such increases, grantees would have to include in their justification reasons why the increased costs could not be covered through rebudgeting within the current grant.

Division of Regional Medical Programs
August 28, 1967

August 1968 Council extended the above authority for one year.
In addition, authority is granted Division staff a program grant period for not longer than six months at the regions' current rate of support.

NOTE: See exerpt from Minutes of Council 8/68 expanding authority.

COUNCIL-DELEGATED AUTHORITY TO
STAFF OF RMPS

Delegation of Authority by National Advisory Council on Regional Medical Programs to the Division of Regional Medical Programs Staff for Administrative Changes in Amounts of On-Going Grants

On August 28, 1967, the Council approved the following delegations of authority to the Division staff to approve increases in amounts for active grants for the following purposes:

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(3) Increases of an administrative nature which do not represent an expansion of the program or change in any significant manner the nature of the program, such as increased costs for equipment, personnel, travel, rental, and alterations and renovations. Such increases would be limited to 15 percent for any budget category and all increases would be reported to the Council.

(4) Rebudgeting of allowable indirect costs to direct cost expenditures with an equivalent reduction in the indirect cost allowance (an increase in direct costs only, not in total grant amount).

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Division of Regional Medical Programs
August 28, 1967

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In addition, authority is granted Division staff a program grant period for not longer than six months at the regions' current rate of support.

NOTE: See exerpt from Minutes of Council 8/68 expanding authority.

XIV. DELEGATION OF AUTHORITY BY NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS TO THE DIVISION OF REGIONAL MEDICAL PROGRAMS STAFF FOR ADMINISTRATIVE CHANGES IN AMOUNTS OF ON-GOING GRANTS

On August 28, 1967, the Council approved the delegation of authority to the Division staff to approve increases in amounts for active grants for four general purposes. The second of these was:

"(2) Extension of grant period with additional funds, at a rate not to exceed the current rate of support, for a period not to exceed six months in order to prevent hardship to personnel or loss of investment already made under the grant, to provide additional time for preparation, review and approval of a renewal application, or to provide for orderly termination of the grant. Such extension would be reported to the Council."

On August 27, 1968, Council approved the further use of this authority in the following circumstances:

"In the case of grants which included commitments for a final budget period of 12 full months but which were arbitrarily shortened (and amounts concomitantly reduced) by the Division's decision to extend commitments no longer than 12 months beyond the life of P.L. 89-239 (June 30, 1969)."

...August 26-27, 1968 Council Meeting

Delegation by the National Advisory Council to the Division of Regional Medical Programs Staff for Administrative Approval of Minor Expansions in Activities Under Approved Operational Regional Medical Programs

The following delegation was approved by the National Advisory Council on August 28, 1967, as the basis for administrative action by the staff within specified limits without reference to Council:

Staff may approve requests for expansion of approved activities or initiation of activities ancillary to the Regional Medical Programs -- up to 5 percent of the total direct cost awarded for the current budget period, but not greater than $50,000 (plus indirect costs). This annual limit would apply whether it is reached in one or more individual requests.

Approval for this delegation of authority would be included in each Council action recommending approval of an operational grant application. Requests must be approved by the Regional Advisory Group and should justify why the increased costs cannot be covered through rebudgeting within the current grant.

Division of Regional Medical Programs
August 28, 1967

August 1968 Council extended the above authority for one year.